Dedicated to the Health
Of the Whole Community

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

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Mental Health Services Act
Summary of Initial (FY11) Innovation Plan

The Innovation (INN) component is one of five major programs of the Mental Health Services Act (MHSA). INN projects are novel, creative and/or ingenious mental health practices or approaches that contribute to learning rather than primarily focusing on providing a service.

Over a 15 month period, the Mental Health Department (MHD) worked with local stakeholders, including consumers and family members, to develop the County's initial INN Plan. The plan was posted for 30 days for public review and comment from April 16 to May 16, 2010. The Mental Health Board (MHB) convened a public hearing for the Initial INN Plan (and FY10-11 Annual Update) on May 18, 2010. The County Board of Supervisors approved the plan on August 24, 2010.

The Initial INN Plan consists of seven distinct projects (aka work plans) ranging in duration from 24 to 36 months. The total cost of the seven projects including MHD administration and evaluation services is projected to be about $13.1 million. The projects would be funded completely from the County's INN allocations. With an estimated start date of November 1, 2010, the table below depicts the projected expenditures for each project and for administration from FY10-11 through FY13-14. The County's submission to the State will include a funding request for FY10-11 ($3.2 million) plus a 10% operating reserve ($319,617) which is not shown below.

	Work Plan	Months	FY11	FY12	FY13	FY14	Total
1	INN-01	24	$ 170,158	$ 235,127	$ 97,970	$ -	$ 503,254
2	INN-02	36	$ 703,529	$ 1,158,907	$ 1,158,907	$ 482,878	$ 3,504,222
3	INN-04	36	$ 252,060	$ 356,675	$ 356,675	$ 118,892	$ 1,084,302
4	INN-05	36	$ 481,791	$ 684,499	$ 684,499	$ 285,208	$ 2,135,998
5	INN-06	36	$ 256,025	$ 438,900	$ 438,900	$ 182,875	$ 1,316,700
6	INN-07	24	$ 285,209	$ 441,788	$ 184,078	$ -	$ 911,075
7	INN-08	32	$ 214,500	$ 60,500	$ 60,500	$ -	$ 335,500
	INN Admin		$ 832,900	$ 832,900	$ 832,900	$ 832,900	$ 3,331,601
			$ 3,196,173	$ 4,209,296	$ 3,814,429	$ 1,902,753	$ 13,122,651

INN-01: Early Childhood Universal Screening

The aim of this 24-month project is to develop a model to increase access to services and improve outcomes by strengthening the screening and referral process for young children with developmental disabilities and social emotional delays through:

1. The use of multi-language electronic developmental screening "kiosks" or stations in pediatrician offices;
2. The use of new audio and video components to augment the electronic screening tools for use by parents who are monolingual in Spanish or have limited English proficiency;
3. Immediate written electronic communication of screening directly to pediatricians and parents regarding screening results;
4. Immediate electronic referral upon pediatrician and/or parental request;
5. The provision of immediate written feedback and "tip sheets" in multiple languages directly to parents about their child's developmental needs;
6. Follow-up telephonic consultation and linkage to evaluations and services for children identified through screening as having potential developmental needs.

If successful, this project will provide a new method of pediatric mental health screening, parent education and referral that is efficient, low cost, and effective in linking parents and their children to mental health and other indicated services.

INN-02: Peer-Run TAY Inn

The aim of this 36-month project is to increase access to services and improve outcomes for high-risk transition age youth in a voluntary 24-hour care setting. The project model is designed to achieve the aim through the implementation of innovative 24-hour services that involve a significant expansion of the role of TAY employees in decision-making and provision of program services.

If peer decision-making and mentoring approaches utilized in the project result in positive outcomes for youth served, stakeholders can integrate the practices more widely into the system of care for transition age youth. Successful outcomes from the project would support broader inclusion of transition age youth views and perspectives in future programming and policy related decision-making.

INN-04: Older Adults

This project develops a model to increase the quality of services for isolated older adults by adapting a culturally-based approach that capitalizes on the traditional role of older adults as transmitters of cultural wisdom and values. The core service will be provided by community workers through a 12-week curriculum where the older adult, in the company of family members and caregivers, is elicited to reminisce on his/her life and express and capture significant memories and personal accomplishments. These shared memories can be commemorated through various expressive arts techniques such as journaling, memory books, videography or digital stories. Venues will be explored to present, celebrate and honor the older adult's life with the larger community.

If successful, the project will provide a method of reducing older adults' depressive symptoms and cognitive decline that is low-cost, engages natural support systems, and can be easily incorporated into the current mental health services programming

INN-05: Multi-Cultural Center

The project develops a model to increase access to underserved and inappropriately served ethnic communities by establishing a Multi-Cultural Center (MCC) designed to house activities and services for multiple ethnic communities. The MCC will offer a welcoming, accessible and safe place where members of all ethnic communities can find a sense of cultural resonance, belonging and support. The MCC will be open to ethnic events and celebrations, creating a natural place for community members to congregate, and where conversations about mental well-being can be inserted and approached within appropriate cultural contexts and languages. Designed and delivered

mainly by ethnic family members and peer mentors, mental health promotion and support services will be grounded in ethnic traditions, and will incorporate healing methods and practices not currently in the system of care.

If successful, this project will demonstrate how the inclusion of multi-cultural services in one setting can facilitate an innovative cross-cultural collaboration between ethnic communities and with the mental health system, resulting in increased capacity and services with higher receptivity levels. It will inform and guide efforts to increase the capacity of new immigrant populations in support of those with mental health issues.

INN-06: Transitional MH Services to Newly Released County Inmates

The aim of this 36-month project is to develop a model that examines whether the organizational support of the Mental Health Department provided to an inter-faith collaborative and coordination and collaboration with other service providers/advocacy groups increases the capacity of faith organizations to serve newly-released inmates and improve outcomes (symptom management; relationships; work/meaningful activities; and satisfaction with service). The project involves:

1. The development of a service that is informed and designed through collaboration between consumer/family members, faith communities, the Mental Health Department, and other service providers/advocacy groups;
2. The development of an engagement and treatment approach that emphasizes the MHSA general standards of service integration and wellness and recovery principles; (3) the development of a sustainable approach designed to increase capacity through coordination for more efficient use of existing resources, and collective responsibility for achieving desired outcomes; and,
3. The voluntary connection of inmates with faith organizations/volunteers who will offer social, emotional, spiritual support as well as advocacy and linkage to access available community resources.

If successful, this project will demonstrate how collaboration between faith organizations, volunteers, the mental health department, and other service providers and advocacy groups can play a role in increasing the community's capacity to support and facilitate successful re-entry of newly released inmates with mental health needs.

INN-07: Mental Health / Law Enforcement Post-Crisis Intervention

The aim of this 24-month project is to develop a model to improve mental health crisis resolution and engagement in services for individuals and their families who experience law enforcement-involved acute mental health crises through the provision of compassionate and timely post-crisis services. The project will include:

1. Post-event visits (within 24-hours) from a team that includes a peer/family mentor and mental health clinician to offer support and education about services;
2. Follow-up support and linkage services as needed to assure resolution of mental health crisis and connection of client and family to needed services; and,
3. De-briefing with law enforcement liaisons, consumer/family mentors and clinical staff to continually inform the effectiveness of service in providing compassionate and wellness and recovery focused support and linkage to appropriate services.

The project is expected to contribute provide qualitative and quantitative data about service engagement and outcomes for those community members to whom police and mental health

resources are deployed. It provides a unique opportunity to from individuals and families in crisis what they consider to be most helpful to them before, during and after mental health crises. This information guide future programmatic and policy responses.

INN-08: Interactive Video Simulator Training

The aim of this 32-month project is to develop a model to bring the perspectives of family members and consumers to law enforcement and improve the quality of officers' response during mental health crisis events through the innovative development of mental health related scenarios for inclusion in widely used interactive video simulator training. The perspectives of mental health consumers and underserved ethnic communities will inform scenario development. The project includes three elements:

1. The development of video simulations informed by and including consumer/family members, including those from underserved ethnic communities;
2. The incorporation of mental health scenarios into existing widely used interactive video simulator training for law enforcement; and,
3. The collection of data to evaluate whether project approach results in improved law enforcement response to individuals and their families.

If successful, this project has the potential to significantly impact law enforcement response to mental health-involved crises in the community through training that exposes them to "real life" scenarios depicting crisis events as they are experienced by individuals and family members from different cultures. The project is expected to improve law enforcement response skills, improve community trust in law enforcement, and improve the overall safety of those involved in mental health crises.

Pending INN Plan Update - INN-03: MH Disorders in Adults with Autism / Developmental Disabilities

As part of the County's community planning process, stakeholders developed and the Board approved an eighth project. However, per direction from the State, the MHD will submit the project by the end of 2010. Submission is delayed to allow the MHD to:

1. Complete of a limited needs assessment and a thorough literature review on the nature and prevalence of the problem, and systemic barriers to treatment;
2. Conduct a review of evidence based practices to determine range of potentially effective treatment approaches; and,
3. Develop a synthesize treatment approach.

The aim of the project would be to improve access to services and improve outcomes for individuals with autism/developmental disabilities and co-occurring mental health disorders through the application of a new synthesized treatment approach informed by problem analysis and best practices. If successful, this project will provide valuable information regarding the prevalence and nature of mental illness among adults with autism in Santa Clara County and will provide further information regarding the design of effective practice for this unique underserved population to be incorporated as needed as a specialized mental health service.

SANTA CLARA COUNTY MENTAL HEALTH SERVICES ACT

Santa Clara County

Initial Innovation Plan

1)	Exhibit A	County Certification
2)	Exhibit B	Community Program Planning and Local Review Process
3)	INN-01 Project Packet (Exhibit C: Narrative, Exhibit D: Budget and Budget Narrative)	
4)	INN-02 Project Packet (Exhibit C: Narrative, Exhibit D: Budget and Budget Narrative)	
5)	INN-04 Project Packet (Exhibit C: Narrative, Exhibit D: Budget and Budget Narrative)	
6)	INN-05 Project Packet (Exhibit C: Narrative, Exhibit D: Budget and Budget Narrative)	
7)	INN-06 Project Packet (Exhibit C: Narrative, Exhibit D: Budget and Budget Narrative)	
8)	INN-07 Project Packet (Exhibit C: Narrative, Exhibit D: Budget and Budget Narrative)	
9)	INN-08 Project Packet (Exhibit C: Narrative, Exhibit D: Budget and Budget Narrative)	
10)	INN Admin Budget & Budget Narrative	
11)	Exhibit E	INN Funding Request
12)	Appendix 1	Comments & Responses from MHB Public Hearing (May 18, 2010)
13)	Appendix 2	Summary of SLC Meeting (July 19, 2010)
14)	Appendix 3	Draft Minutes of the MHB Meeting (July 19, 2010)
15)	Appendix 4	Summary of Substantive Changes to INN Plan

EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: Santa Clara

County Mental Health Director	**Project Lead**
Name: Nancy D. Pena, Ph.D. Telephone Number: 408-885-5782 E-mail: Nancy.Pena@hhs.sccgov.org	Name: Gabriela Deeds, LCSW Telephone Number: 408-423-0702 E-mail: Gabriela.Deeds@hhs.sccgov.org
Mailing Address: County of Santa Clara Santa Clara Valley Health and Hospital System, Mental Health Department 828 South Bascom Avenue San Jose, CA 95128	Mailing Address: County of Santa Clara Santa Clara Valley Health and Hospital System, Mental Health Department 828 South Bascom Avenue San Jose, CA 95128

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

	9/3/10	
Signature (Local Mental Health Director/Designee)	Date	Director, Mental Health Department

EXHIBIT B

INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name: Santa Clara
Work Plan Name: Initial Innovation Plan

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)

The County's Initial Innovation Plan, consisting of eight distinct work plans, was developed with community input over a period of 15 months. The County's MHSA Stakeholder Leadership Committee (SLC) oversaw the process. See attached INN Planning Process Graphic.

First, the SLC authorized the formation of a sub-committee to develop focus areas for potential Innovation (INN) projects. The four focus areas were endorsed by the community in the summer of 2009.

Second, with stakeholder endorsement, the MHD solicited "innovative ideas" from the community. The MHD accepted all submitted ideas as potential starting points for an INN Work Plan. The MHD translated forms, made presentations, and enlisted consumers, family members and members of underserved racial/ethnic communities to encourage and support broad participation. In all, the MHD received 150 distinct ideas.

Third, in a public setting, the SLC members and other stakeholders identified the ideas that should be developed into full Work Plans. Over 150 individuals participated in the process. Utlimately, the SLC reviewed all of the community input and endorsed an approach that would ensure that the County's INN plan would address the entire lifespan while reflecting the strong preferences of the community. Staff from the MHD then applied the INN guidelines to each of the selected "ideas" and developed preliminary Innovation Concepts.

The fourth step involved convening multiple public input sessions for each of the Innovation Concepts to clearly define the core problem/issue, the barriers to solving the problems, possible solutions and learning objectives. Information for all input sessions were broadly disseminated and open to the public. Overall, the MHD held nearly 30 public meetings or focus groups to take the ideas from Innovation Concepts to Draft Work Plans.

Stakeholders in public input and plan development meetings were informed through written and verbal communication about the Innovation guidelines. Program staff also borrowed from materials prepared and posted other counties websites to explain Innovation guidelines. The Innovation Decision Path worksheet was provided to stakeholders in at least one of the planning meeting for each project and also at the Stakeholder Leadership Committee meeting. A modified version of a CIMH Innovation planning worksheet was used in several planning meetings for the Older Adult and Post-Crisis Intervention projects.

2. Identify the stakeholder entities involved in the Community Program Planning Process.

Below is a partial list of entities that participated in developing the Innovation Plan.

- The Stakeholder Leadership Committee (SLC) consists of 40-45 representatives of various stakeholder groups, including consumers, family members and underserved cultural communities. The SLC meets approximately once each month and is the MHD's primary advisory body for MHSA activities.
- Mental Health Board (MHB) members and sub-committee members.
- Members of underserved communities, including participants of the County's Ethnic and Cultural Community Advisory Committees (ECCACs) which advise the department on how to improve services for over 10 underserved ethnic and cultural groups.
- Staff and managers, including clinicians, case managers and medical professionals of the Mental Health Department, organizations providing mental health services, social services and partner organizations such as First Five.
- Faith-based organizations.
- Law enforcement agencies, the courts and criminal justice agencies (e.g. Juvenile Probation) and mental health advocates.
- Consumers and family members including organizations that represent them such as the National Association of Mental Illness.
- Representatives from the education sector, including Special Education.

Family and consumer participation in Innovation planning was elicited in a variety of ways. Family and consumer partner employees and other consumer representatives were in attendance at the majority of planning meetings for Innovation projects. Approximately 45 consumers/family members attended one or more of the Innovation planning meetings. Twelve of those consumer/family members represented underserved ethnic community groups in one meeting to plan for the Multi-Cultural Center project. Underserved ethnic community consumer/family members were also actively involved in planning for projects 6, 7, and 8.

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

The plan was posted for 30-day stakeholder review from April 16, 2010 to May 16, 2010. The public hearing was convened by the Mental Health Board on May 18, 2010.

MHD staff made significant changes/additions to all eight INN plans based on comments received from: OAC staff, MHB May 18 public hearing, MHD staff reviews, and additional stakeholder input through public input meetings.

Appendix 1 details the comments the MHD received at the Public Hearing. MHD reponses are also included.

Appendix 2 is a summary of the SLC meeting of July 19, 2010.

Appendix 3 are draft minutes of the MHB meeting on July 19, 2010.

Appendix 4 is a summary of the substantive changes to the INN Plan and the plan's eight projects.

MHD staff improved the plans significantly through inclusion of additional information with respect to program components, budgets, aims and success measures of projects, possible outreach strategies, and statements about how lessons learned will impact the system of care. MHD staff also provided further details about project implementation including staffing, evaluation, and the role of the Learning Advisory Committees.

Finally in order to share information about the significantly updated INN plans, MHD staff held a special joint SLC and MHB meeting on July 19. During the meeting, 2-4 stakeholders for each project presented about the substantive additions made to the plans in response to comments.

After all presentations were delivered and time provided for questions for each project, the SLC and the MHB voted overwhelmingly to approve all Innovation plans.

Innovation Work Plan Narrative

Date: 09/03/10

County: Santa Clara

Work Plan #: INN-01

Work Plan Name: Early Childhood Universal Screening Project

Purpose of Proposed Innovation Project (check all that apply)

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☐ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☒ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

In 2005 the Centers for Disease Control reported that 17% of children in the United States have a developmental or behavioral disability such as autism, mental retardation, and Attention-Deficit/Hyperactivity Disorder. In addition, many children have delays in language or other areas which impact school readiness. However, less than 50% of these children were identified as having a problem before starting school, by which time significant delays may have already occurred and opportunities for treatment were missed. Santa Clara County does not have a universal screening system for identifying children with delays, disabilities, and behavior concerns. As a result, many children in the County are missing a vital opportunity for early detection and intervention.

The American Pediatric Association recommends the use of standardized developmental screening of young children during well child medical examinations. Research has shown that when clinical judgment is complimented by the use of a standardized screening tool, the rate of detection increases significantly for young children with possible social emotional and developmental delays.

Despite this recommendation and the availability of screening tools, standardized universal screening practices have not been adopted by Santa Clara County public pediatric clinics. Santa Clara County is not alone as the majority of pediatricians nationally also have not adopted the practice. According to research, the reluctance to adopt universal screening tools is due to concerns about the amount of staff, time, and cost necessary to complete screenings.

From December 2007 to June 2009, the California Department of Public Health completed paper-based developmental screenings in two Santa Clara County pediatric clinic sites as part of a study of children with autism. The majority of the children (75%) screened were Hispanic and many of them had mono-lingual Spanish-speaking parents with limited or no English language skills. The developmental screening tool that was used was the Ages and Stages Questionnaire (ASQ) and Ages and Stages

Questionnaire - Social Emotional (ASQ-SE.) The ASQ is a popular tool because it can be completed quickly and relies on a simple self-report survey of parents about their child's development. The survey is designed to be self-administered; however due to literacy factors, research staff often read the survey aloud and recorded parents' answers. Aside from the researchers, the study required two full-time staff to coordinate and schedule screenings and ensure that screenings were completed, scored and provided to pediatricians. During the project, approximately 70% of all the eligible children were screened. However, no plans were developed for medical office staff to assume responsibility for screenings after the research project ended in 2009. After the research project ended, standardized screenings in county clinics ceased and have not resumed to date.

According to County pediatricians, one of the major barriers to continuing standardized screening was the length of time and staff support needed to conduct paper-based screenings in the clinic. Another major problem was the inability of monolingual Spanish-speaking parents to complete the surveys independently. This limited parents' abilities to partner with medical staff in identifying developmental and mental health concerns of their children. Parents with limited English skills faced similar problems.

While studies validate the benefit of standardized screening practices in pediatric clinics, the authors acknowledge the limitations of a paper-based screening system. In a September 2007 article in the journal Pediatrics (Impact of Implementing Developmental Screening at 12 and 24 months in a Pediatric Practice) the authors pointed to multi-language internet-based electronic screening tools with video and voice synthesis capabilities as a possible solution. Since that article was published, online screening tools have become available in Spanish and English. However, it appears that very little if any research has been conducted into whether electronic versions have increased the adoption of standardized screening practices or increased access of underserved populations with language limitations to screenings.

Therefore the County proposes to develop a model utilizing technological innovations to make the adoption of standardized screening practices more feasible for pediatricians and expand access of the tool to underserved populations with language limitations.

A new solution is needed to ensure that more of the County's 153,740 children under the age of six are screened for potential developmental concerns and delays to protect their mental health. This solution must address the needs of children from underserved communities, especially Spanish-speaking parents with limited English ability or limited literacy skills because they represent the majority of children served in County pediatric clinics.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

The aim of this project is to develop a model to increase access to early intervention services and improve outcomes for young children in Santa Clara County, especially for monolingual Spanish-speaking parents. The project studies how the use of an electronic adaptation of existing paper-based screenings impacts utilization by pediatricians. This project addresses the missed opportunities for early of identification of children with developmental needs in Santa Clara County due to the lack of effective and accessible screening practices.

This project will place internet-based screening tools in primary health care settings in the Santa Clara Valley Health and Hospital System. Computer stations or kiosks with developmental screening software will be placed in one or more pediatric clinics. The screening tools to be used are the Ages and Stages Questionnaire and Ages and Stages Questionnaire: Social and Emotional (available in Spanish and English.) The County will also have an opportunity to pilot the use of a soon-to-be-released Spanish language audio component designed to help monolingual Spanish speaking parents with limited reading ability independently (or with little assistance) complete the screening tool.

Parents/guardians would complete the tool prior to meeting with their child's pediatrician as part of their routine well-baby/well-child check. In the clinic, the pediatrician will be provided with computer generated screening results prior to the child's appointment and will be able to provide immediate follow-up to parents on the same day during the appointment.

In addition to the screening and consultation with the pediatrician, the project will provide two service elements. First, from the pediatrician or the screening kiosk, parents will receive information about appropriate developmental age level tasks, areas for growth, and activities they can do with their child to strengthen the child's skills. Second, parents and their children will be connected to a developmental pediatrician or other specialist when concerns are detected. Project staff will provide feedback to the child's pediatrician about results of specialized evaluations and early intervention services accessed by the child's family.

MHD staff, in conjunction with pediatricians, will develop appropriate outreach and educational materials (including electronic and web-based) to assist parents and

medical staff effectively utilize the screening tool, access related information and manage assessment and early intervention services as needed.

This project is expected to result in the design of a sustainable screening system for a pediatric clinic setting which utilizes existing medical staff as much as possible and increases independent accessibility to parents from underserved communities with language limitations.

This project is aligned with the following MHSA general standards:

Cultural Competence: The project will utilize a completely new Spanish language audio component (to be released in Oct 2009) designed to increase independent access to developmental screening for Hispanic clients who represent the highest number of families and children served in County pediatric clinics. Provisions will be made for parents of children who speak languages that are not available in the electronic version of the ASQ.

Integrated Service Experience: The project improves the collaboration between pediatrician's and behavioral health professionals.

Consumer and Family Driven Mental Health System: The project places parents/caregivers in a stronger position to advocate for their child's healthy development by enabling them to independently complete surveys and providing them with information before they meet with the child's pediatrician for a well-baby/well-child appointment.

Community Collaboration: This project expands collaboration between parents and pediatricians and increases coordination between behavioral and primary health care providers and other system partners.

Wellness, Recovery, Resiliency Focus: This project promotes recovery for young children by detecting developmental and mental health concerns early in their lives when treatment has the best chance of achieving maximum recovery and wellness.

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

This project meets Innovation criteria by adapting an existing practice of standardized developmental screening in pediatric settings. Monolingual Spanish-speaking parents, and those with limited English skills, will be able to access an electronic screening tool with new Spanish audio and video components. The project assumes that the use of an electronic tool will increase utilization by pediatric staff in the clinic and that the Spanish audio and video components will increase the participation of parents, thereby bringing the County closer to the goal of universal screening.

The County will learn how to improve utilization of screening tools by monolingual Spanish-speaking parents and medical staff. Surveys will be utilized to assess ease of use and comfort levels with technology and to assess whether parents/caregivers increased their utilization of screening tools, increased their understanding about their child's developmental profile and increased access to follow-up services. Medical office staff and pediatricians will share their experiences and help the MHD identify the benefits and challenges associated with use of the technological innovations.

The learning questions are as follows:

Process Question 1: How does the design of kiosk and system for implementation of standardized screening affect access for parents and children to appropriate supports?

Process Question 2: How does the audio version of this screening tool affect access and usability by monolingual and Limited English Proficiency Spanish-speaking parents?

Process Question 3: How does the electronic version of screening and new audio/video components impact medical staff willingness to implement standardized universal screening?

Outcome Question1: Does the innovation increase the number of children being screened and linked to follow-up evaluations and indicated services?

Outcome Question 2: Does the innovation impact monolingual Spanish parents' capacity in identifying and partnering with medical staff to obtain needed evaluations and services for their children?

If successful, this project will provide a new method of pediatric mental health screening, parent education and referral that is efficient, low cost, and effective in linking parents and pediatricians to mental health services.

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: NOV 2010 – OCT 2012
MM/YY – MM/YY

October 2010:

- Approval from OAC
- Establish Learning Advisory Committee (LAC) to refine project assessment plan including final success measures, data indicators and reporting infrastructure.
- Work with pediatricians and medical staff to plan for design and implementation of adapted screening tool.
- Completion of design of a station or kiosk for adapted screening tool and design for screening implementation system for use in pediatricians' offices.

November 2010 – December 2010

- Hire staff and develop outreach materials.
- Purchase and install equipment and software.
- Complete all necessary training.

January 2011 – June 2012

- Begin utilization of electronic screening tool.
- Convene LAC quarterly to assess progress towards learning goals, modify project model, assess challenges, and make recommendations. Discuss feasibility of project replication or systems change if project is successful.

July 2012 – Present draft project report with recommendations for inclusion of lessons learned.

October 2012 – Present final project report with initial feasibility for sustaining, integrating or replicating project services or lessons learned to MHD staff, Mental Health Board and the Stakeholder Leadership Committee.

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an advisory capacity to the project staff for the life of the project. While the membership of each Learning Advisory Committee will be different, all Learning Advisory Committees will include consumers and/or family members, providers, system partners and MHD staff. When appropriate, existing stakeholder groups, committees or task forces will be utilized.

Facilitated and supported by MHD staff, each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members finalize project success measures, monitoring tools and reporting infrastructure. This will ensure that stakeholders, the MHD and project staff have clearly defined objectives and measurement tools.

Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and outcome data. In this role, stakeholders assist staff implement the project by advising on operational issues such as vetting data indicators, problem solving, reviewing reports and connecting clients to other services. The LAC continually assesses the project's progress toward the stated aim, and makes recommendations on how to modify services or activities if objectives (i.e. success measures) are not being achieved.

Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned. In this role, members help connect the project's contributions to the broader system(s) of care.

Final project reports and recommendations will be provided to system partners, the County's Stakeholder Leadership Committee, the Mental Health Board and the Board of sustainability of approach if project is successful and consider how communication about lessons learned will be accomplished.

At this time, the following measures are proposed for each learning question:

Process Question 1: How does the design of kiosk and system for implementation of standardized screening affect access for parents and children to appropriate supports?

Measure: Survey parents on how each element of this operation structure (screening at pediatrician offices at well-check visit, screening support staff, pediatrician's exam using data from screening report, clinician's coordination of services) is supportive of parents

getting appropriate support for their children in need of mental health or developmental services.

Process Question 2: How does the audio version of this screening tool affect access and usability by monolingual and Limited English Proficiency Spanish-speaking parents?

Measure: Survey parents on their experience in using the audio screening tool (comfort level, user-friendliness, appropriateness of terms used, mode of interaction between tool and parent, usefulness of suggestions/activities for use with children, learning value of experience of using tool, etc)

Measure: Survey parents on the impact of (this method) in their capacity to identify their children's developmental, social, and emotional levels, their confidence in understanding developmental, social, and emotional development and their ability to work in partnership with MHD to access appropriate levels of services and support

Process Question 3: How does the electronic version of screening and new audio/video components impact medical staff willingness to implement standardized universal screening?

Measure: Survey medical staff about ease of use and satisfaction levels with system design fro implementation of screenings.

Outcome Question1: Does the innovation increase the number of children being screened and linked to follow-up evaluations and indicated services?

Measures: Record number of children being screened, number of children evaluated by pediatrician, number of children referred by pediatrician for further evaluation, and number of children engaged into MH services.

Outcome Question 2: Does the innovation impact monolingual Spanish parents' capacity in identifying and partnering with medical staff to obtain needed evaluations and services for their children?

Measure: Survey parents on the impact of (this method) in their capacity to identify their children's developmental, social, and emotional levels, their confidence in understanding developmental, social, and emotional development and their ability to work in partnership with MHD to access appropriate levels of services and support

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

First Five may provide in-kind staff support screeners/care managers to assist at clinic pilot sites with screening or follow-up case management for children/families requiring further evaluation/services.

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Santa Clara

Work Plan Name

Early Childhood Universal Screening Project

Annual Number of Clients to Be Served (If Applicable)
700 Total

Population to Be Served (if applicable):

Children ages 0 - 5 and their parents/caregivers, largely from underserved ethnic communities, who receive primary care at County clinics or partner clinics in the community.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

Vital opportunities to identify and treat children with developmental needs in Santa Clara County are being missed due to the lack of effective and accessible screening and referral processes that allow smooth and efficient linkage between parents and children, pediatricians and specialty mental health services. The aim of this 24-month project is to develop a model to increase access to services and improve outcomes by increasing the number young children who are screened for developmental disabilities and social emotional delays.This project seeks to achieve the aim through the incorporation of the following innovative service elements:

1. The development of a model utilizing electronic screening that is feasible and sustainable in a public pediatric clinic settings;
2. The incorporation of a Spanish audio component of the ASQ-III to increase independent access to the tool for monolingual Spanish populations. During the life of the project if audio versions of the tool become available in other languages, the county will incorporate those as well.)
3. Immediate written electronic communication of screening directly to pediatricians and parents regarding screening results;
4. Immediate electronic referral upon pediatrician and/or parental request;
5. The provision of immediate written feedback and “tip sheets” in multiple languages directly to parents about their child’s developmental needs;

If successful, this project will increase the use of standardized electronic developmental screenings that are accessible to populations with limited English proficiency or literacy.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Santa Clara Fiscal Year: 2010/11

Work Plan #: INN-01

Work Plan Name: Early Childhood Universal Screening

New Work Plan ☑

Expansion ☐

Months of Operation: 11/10- 6/11
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	72,520			$72,520
2. Operating Expenditures	67,638			$67,638
3. Non-recurring expenditures	30,000			$30,000
4. Training Consultant Contracts				$0
5. Work Plan Management	0			$0
6. Total Proposed Work Plan Expenditures	**$170,158**	**$0**	**$0**	**$170,158**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$170,158**	**$0**	**$0**	**$170,158**

Prepared by: Jeanne Moral Date: 9/3/2010

Telephone Number: 408-885-6867

Budget Narrative

Fiscal Year 10-11

Note: All amounts represent annualized amounts for the first year of the project's operation.

Innovation Program: INN-01 – Early Childhood Universal Screening Project

A. Expenditures

Personnel Expenditures:
Staffing costs reflect a full-time mental health clinician ("Care Manager") to provide assessment, follow-up case management for evaluation and service linkage for children who are identified through the screening process. The project requires a feedback loop to pediatricians regarding the outcomes of completed evaluations and follow-up services that are provided.

Operating Expenditures:

- General operating expenses (office supplies, phones, mileage, etc.) are calculated at 10% of personnel expenses.
- $77,000 is set aside to cover the cost of software licenses for the electronic screening tool, additional screens, software programming, networking, outreach/education materials, and maintenance costs for hardware.
- Overhead expenses are calculated at 10% of total program expenditures.

Non-Recurring Expenditures:
The expenditure of $30,000 includes the cost of computers, printers, furniture necessary to house the work stations. The project will be piloted in several locations, each with one or two work stations.

B. Revenues

To be determined.

Innovation Work Plan Narrative

Date: 09/03/10

County: Santa Clara

Work Plan #: INN-02

Work Plan Name: Peer-Run Transition Age Youth Inn

Purpose of Proposed Innovation Project (check all that apply)

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☐ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☒ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

Stakeholders prioritized the unique needs of transition age youth (TAY) – especially those who have been involved with the juvenile justice or foster care systems – as an area of concern that required innovative solutions. Many are at greater risk for mental health problems and homelessness due to their traumatic experiences. TAY who are homeless or in crisis face numerous barriers to accessing and successfully engaging in mental health services and supports. As a result, many TAY suffer devastating consequences of long-term homelessness, drug and alcohol addiction, prostitution, avoidable psychiatric hospitalizations, and incarceration.

One significant hurdle is that TAY may not yet have the age-related developmental skills necessary to successfully access services and supports designed for adults. TAY are also especially impacted by stigma associated with mental illness and thus are less likely than adults to access services prominently identified as relating to mental health and delivered in traditional clinic settings. In addition, TAY may not be amenable to services that are provided by adults; local TAY expressed a strong preference for services staffed and informed by people who look like them and who have had similar life experiences.

For homeless TAY or those in crisis, effective programs must include strategies that address stigma to encourage TAY to access mental health services and supports in a safe 24-hour setting. Research demonstrates that peer mentoring approaches are being widely utilized to reduce stigma and engage high risk transition age youth. However, these approaches are focused on outreach as a means of helping TAY access services that are delivered primarily by adults. Peer staffing components have only recently begun to be offered in the County for TAY programs. This project proposes a new model that expands the decision-making responsibilities and roles of TAY partners for use in a 24-hour setting to engage and help TAY stabilize.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

The aim of this project is to develop a model to expand the leadership capacity of TAY partners in the delivery of services in a voluntary 24-hour care setting to improve access and outcomes for high-risk TAY residents. The program will target TAY who are homeless or who find themselves in need of shelter as a result of a critical situation. Peer partners will engage youth and champion the value of the service. Outreach efforts will be led by peer partners and will target local homeless centers, TAY providers, and homeless youth.

Peer partners, with support from adult staff, will have significant input in designing services and managing day-to-day operations. The peer partners will also be the primary provider of program services. Programs offered at the inn will be informed by wellness and recovery approaches that are effective in helping youth develop skills and capacity to achieve life goals.

In addition to helping youth stabilize and gain self-awareness and skills in a safe environment, the inn will also serve as a bridge for entry into appropriate ongoing services and supports in the broader system of care. Given TAY characteristics, the program will relax eligibility requirements and de-emphasize connections with “mental health services and supports” whenever possible. A process will be developed to enable all providers in the system of care to refer youth to the inn. By offering a peer-led, recovery-based, 24 hour care approach to youth facing crises and/or homelessness, the project is expected to result in more effective engagement of and improved life outcomes for TAY in the County.

The program model will be designed to expand decision-making and leadership capacities for peer partners through the following three components: training, day to day management of the inn, and participation on the learning advisory committee.

The program model will also be designed to increase the self-determination and self-advocacy skills for TAY residents through extensive mentoring from trained peer partners in activities such as co-facilitated groups (with adult staff), developing transition plans, and participation in daily living/work activities with peers at the inn.

One of the leadership training components for peer partners, based on the person-in-environment model, will expand their awareness of how social, economic, and political factors influence life experience. This training component also explores the ways that increased awareness can be translated into advocacy activities to improve the systems of care for TAY.

TAY peer partners will utilize knowledge gained from the leadership training in their work with TAY residents. Peer partners will work with residetns to develop their awareness of social, economic, political dimensions in shaping life experience and to help residents begin to build self-advocacy and self-determination skills in their own transition planning.

The project is consistent with the following MHSA general standards:

Community Collaboration - The project contributes to increased cooperation between TAY system of care providers by establishing a open process to refer youth to the Inn.

Cultural Competence - Demographics for high-risk TAY include underserved community members, including those with limited English-language ability. The Inn will utilize linguistically and culturally compentent practices to serve these youth.

Client Driven Mental Health System - The project utilizes peer partners in all aspects of the project including: staffing, implementation, evaluation, and dissemination of lessons learned.

Family Driven Mental Health System - Youth residents will be encouraged to consider how inclusion of family members and friends in their transition plan could be helpful in achieving goals. The learning advisory committee for the project will include a TAY family member.

Wellness, Recovery, and Resilience Focus - The project design is based on principles that encourage wellness and recovery in TAY including: relaxation of restrictive eligibility criteria, voluntary alternative for youth in crisis, engaging youth in process of developing self-awareness and skills to increase capacity for life goal achievement.

Integrated Service Experience - The inn will be open to referrals from all providers in the TAY system of care and will serve as a bridge for entry into services and supports in the broader system of care.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

The project meets MHSA Innovation guidelines by adapting the existing mental health approach of peer mentoring for use in a 24-hour care setting serving TAY. This project has two innovative elements. First, the project places TAY peer partners in key decision-making roles. The peer partners will significantly manage the day-to-day operations of the inn and will have primary responsibility for developing and designing program services. Second, TAY peer partners will be the primary support and service provider for the TAY residents. The project examines whether the experience of receiving services in an environment chiefly designed and offered by peers will improve engagement of and outcomes (symptom management; relationships; living situation; school/work, and satisfaction with service) for TAY.

The following learning questions will be answered in assessing the project:

Process Question 1. How does playing a lead role in designing, managing and evaluating a peer-run program impact the leadership and decision-making capabilities of peer partners? What allows the peer partners to successfully fulfill their roles?

Process Question 2. How does serving as the primary service provider for TAY residents impact TAY peer partners' leadership skills, decision-making and effectivenss in serving clients.

Process Question 3. How does participation in a peer-run program impact the recovery of TAY residents?

Process Question 4. How does the peer-to peer relationship (peer partner as primary service provider) impact the recovery of TAY residents?

Outcome Question 1. What is the impact of peer partner designed services on functional change of TAY residents in symptom management, quality of relationships, living situation, and school/work?

Outcome Question 2. What is the impact of peer-run and designed services in a 24 hour voluntary setting on increasing access and engagement of high-risk TAY?

If peer decision-making and mentoring approaches utilized in the project result in positive outcomes for youth served, stakeholders can integrate the practices more widely into the system of care for transition age youth. Successful outcomes from the

project would support broader inclusion of TAY views and perspectives in future programming and policy related decision-making.

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: NOV 2010 - OCT 2013
MM/YY – MM/YY

October 2010 – Approval from OAC

October 2010 – November 2010
- Establish Learning Advisory Committee (LAC) to refine project assessment plan including final success measures, data indicators and reporting infrastructure.
-Completion of a training curriculum for youth mentors endorsed by the Learning Advisory Committee (LAC);
- Finalize project implementation plan and service model.
- Issue Request For Proposal.

Dec 2010 - March 2011
- Complete RFP process and award contract
-Recruitment, training and employment of youth mentors per above curriculum;
-Completion of a youth informed engagement and service model endorsed by LAC;
- Establish program site

April 2011 - Begin program services

July 2011 - April 2013 - Convene learning advisory committee to conduct quarterly reviews and monitor programs for progress towards learning goals (1) Collect, compile, review, and assess data (2) recommend changes and adjustments, including changes as needed to design of project model (3) initiate discussion about how project will be sustained if successful through alternative funding sources or system transformation (4) Discuss and make recommendations for how learning results from project will be communicated/shared.

July 2013 - Present draft project report with initial feasibility for sustaining, integrating or replicating project services or lessons learned to MHD staff, Mental Health Board and the Stakeholder Leadership Committee.

October 2013 - Issue final report

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an advisory capacity to the project staff for the life of the project. While the membership of each Learning Advisory Committee will be different, all Learning Advisory Committees will include consumers and/or family members, providers, system partners and MHD staff. When appropriate, existing stakeholder groups, committees or task forces will be utilized.

One or more peer partners will participate on the learning advisory committee for the project. Facilitated and supported by MHD staff, each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members finalize project success measures, monitoring tools and reporting infrastructure. This will ensure that stakeholders, the MHD and project staff have clearly defined objectives and measurement tools.

Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and outcome data. In this role, stakeholders assist staff implement the project by advising on operational issues such as vetting data indicators, problem solving, reviewing reports and connecting clients to other services. The LAC continually assesses the project's progress toward the stated aim, and makes recommendations on how to modify services or activities if objectives (i.e. success measures) are not being achieved.

Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned. In this role, members help connect the project's contributions to the broader system(s) of care.

Final project reports and recommendations will be provided to system partners, the County's Stakeholder Leadership Committee, the Mental Health Board and the Board of Supervisors.

Learning questions will be measured by the following data indicators:

Process Question 1. How does playing a lead role in designing, managing and evaluating a peer-run program impact the leadership and decision-making capabilities of peer partners? What allows the peer partners to successfully fulfill their roles?

Process Question 1 Measure: 1. Self-report surveys of peer partners as per tool endorsed by the Learning Advisory Committee.

Process Question 2. How does serving as the primary service provider for TAY residents impact TAY peer partners' leadership skills, decision-making and effectivenss in serving clients.

Process Question 2 Measures: Self-report surveys and level of participation in transition planning of TAY residents as per tool endorsed by the Learning Advisory Committee

Process Question 3. How does participation in a peer-run program impact the recovery of TAY residents?

Process Question 3 Measures: Self-report surveys of TAY residents as per tool endorsed by Learning Advisory Committee.

Process Question 4. How does the peer-to peer relationship (peer partner as primary service provider) impact the recovery of TAY residents?

Process Question 4 Measures: Self-report surveys of residents and surveys of peer partners as per tool endorsed by the Learning Advisory Committee.

Outcome Question 1. What is the impact of peer partner designed services on functional change of TAY residents in symptom management, quality of relationships, living situation, and school/work?

Outcome Question 1 Measures: Measure of functional change in major life domains as per tool endorsed by the Learning Advisory Committee.

Outcome Question 2. What is the impact of peer-run and designed services in a 24 hour voluntary setting on increasing access and engagement of high-risk TAY?

Outcome Question 2 Measures: Documented number of youth accessing and completing program services at the Inn.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

None identified

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Santa Clara

Work Plan Name

Peer-Run Transition Age Youth Inn

Annual Number of Clients to Be Served (If Applicable)
68 Total

Population to Be Served (if applicable):

Transition Age Youth (including youth aging out of foster care) who are homeless/at-risk of homelessness or experiencing mental health crises.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

High risk transition age youth who are homeless or in crisis face numerous barriers to accessing and successfully engaging in mental health services and supports. As a result, these youth often suffer devastating consequences of long-term homelessness, drug and alcohol addiction, prostitution, avoidable psychiatric hospitalizations, and incarceration. Local transition age youth have expressed a strong preference for services staffed and informed by people who look like them and have had similar life experiences. Highly specialized innovative approaches designed to successfully engage transition age youth are required in order for them to change the course of their lives in a positive direction.

The aim of this 36-month project is to increase access to services and improve outcomes for high-risk transition age youth in a voluntary 24-hour care setting. The project model is designed to achieve the aim through the implementation of innovative 24-hour services that involve a significant expansion of the role of TAY employees in decision-making and provision of program services.

If peer decision-making and mentoring approaches utilized in the project result in positive outcomes for youth served, stakeholders can integrate the practices more widely into the system of care for transition age youth. Successful outcomes from the project would support broader inclusion of transition age youth views and perspectives in future programming and policy related decision-making.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Santa Clara Fiscal Year: 2010/11

Work Plan #: INN-02

Work Plan Name: Peer Run TAY Inn

New Work Plan ☑

Expansion ☐

Months of Operation: 11/10- 6/11
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			444,687	$444,687
2. Operating Expenditures			233,842	$233,842
3. Non-recurring expenditures			25,000	$25,000
4. Training Consultant Contracts				$0
5. Work Plan Management				$0
6. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$703,529**	**$703,529**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$703,529**	**$703,529**

Prepared by: Jeanne Moral Date: 9/3/2010

Telephone Number: 408-885-6867

Budget Narrative

Fiscal Year 10-11

Note: All amounts represent annualized amounts for the first year of the project's operation.

Innovation Program: INN-02 – Peer-Run Transition Age Youth Inn

A. Expenditures

Personnel Expenditures:
Staffing costs reflect salaries and benefits for 7.0 full-time equivalent (FTE) part-time peer partners, 1.0 FTE program manager, 2.8 FTE shift supervisors and approximately four hours of psychiatric consultation per week. This staffing level ensures that the program can be operated 24 hours a day, seven days a week; each shift would include at least one peer mentor.

Operating Expenditures:
- General operating expenses (office supplies, phones, mileage, etc.) are calculated at 10% of personnel expenses.
- Facility expenses, including leasing and maintenance are calculated at $2.50 per square foot per month. It is estimated that the site would be approximately 5,000 square feet ($150,000 annually).
- The site will provide three meals to approximately 8 clients per day. Food expenses are budgeted at $25,000 per year.
- $10,000 is set aside for program supplies and educational materials.
- Overhead expenses are calculated at 10% of total program expenditures.

Training Consultant Contracts:
$30,000 is set aside for training, consultation and technical assistance to peer partners and staff.

Non-Recurring Expenditures:
$25,000 is allocated for the purchase of furniture, equipment and services associated with establishing the program.

B. Revenues
To be determined.

Innovation Work Plan Narrative

Date: 09/03/10

County: Santa Clara

Work Plan #: INN-04

Work Plan Name: Older adults

Purpose of Proposed Innovation Project (check all that apply)

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

Throughout each of the MHSA's community planning processes the stakeholder community in Santa Clara County raised concerns about the unmet behavioral health needs of older adults (ages 60 and over), especially those who are isolated, physically or emotionally. Primary among the stakeholders' concerns were older adults' emerging or unmitigated symptoms of depression and/or cognitive decline. Depression is the most prevalent disorder among older adults (60+) who receive services from the County's public mental health system. In 2003, 42.1% of older adult consumers received treatment for depression as their primary clincal diagnsosis.

Stakeholders and staff were equally alarmed by the public mental health system's apparent difficulty in effectively engaging and serving older adults. Among the age groups served in the County's public mental health system, older adults are under-represented, and are a rapidly growing population. Demographic data show that the number of older adults will increase from 314,517 (or 13.1% of total population) in 2010 to 667,386 (or 24.5% of the total population) by 2050. Mental health providers acknowledged that older adults are difficult to engage into mental health services due to generational stigma and misconceptions about mental illness and the benefits of mental health services. Typically, physical (e.g. the lack of transportation, poor mobility) and linguistic conditions are obstacles to older adults accessing services. Physically and emotionally isolated older adults may have unrecognized mental health issues and are at risk of developing mental health symptoms, such as anxiety and depression, which can lead to serious mental illness and suicide.

While more services, partnerships and resources will absolutely be required, the County's stakeholders recognized that new approaches are also necessary given many older adult's ethnic and cultural heritages. In addition to a rapidly growing older adult population, the County is home to an extremely diverse population. Currently two-thirds of the County's residents are immigrants or are the first born generation of immigrants. Stakeholders prioritized the development new approaches to engaging and serving the

County's ethnically-diverse older adults, many of whom celebrate the primacy of familial relationships.

Older adults from ethnic communities are especially susceptible to isolation and loneliness. Many immigrants come from traditions of living in extended, multi-generational families in which they retain important roles as mentors and caregivers to grandchildren. Yet many immigrants find that lifestyle choices and "western" social demands do not necessarily support their conceptions of the family unit. Many older adults live alone and do not have family members actively participating in care-giving. Even those who live close by family members experience disconnection due to widening gaps between them and subsequent generations. Even when they live at home, language and cultural differences between recently immigrated grandparents and more acculturated grandchildren result in further disintegration of family relationships.

Stakeholders acknowledged that while physical and linguistic barriers can be overcome, cultural conditions often serve as barriers to both access and effective services (e.g. stigma, discrimination, differing views about mental health, and traditional wellness approaches). Elders from ethnic communties hold severe stigma about mental illness, and many experience western mental health medication treatment, counseling or therapy as counter-cultural and ineffectual.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

The aim of this project is to increase the quality of services, including better outcomes, for isolated older adults who are predisposed to emerging mental health issues, or who have unrecognized mental health symptoms.

Older adults from underserved cultural and ethnic groups will participate in a 12-week interactive activity where they are elicited to reminisce, capture and express their life stories to an interested audience, especially family members and caregivers. Many ethnic traditions place a high value on the role of elders in their families and societies. Elders, reflecting on their own life experiences, impart wisdom by telling life stories and sharing personal experiences. Through that practice, elders transmit cultural knowledge and values, and contribute to maintaining cohesive families and strong communities. In such valued, important and recognized roles, elders remain connected to community daily events, stay actively engaged in the lives of friends and family members, and maintain self-confidence and pro-active approaches to life.

This project will use the main techniques of life review and story telling while engaging natural support systems. The Mental Health Department (MHD) will work with stakeholders and experts to develop a model for helping older adults reminisce, capture and express their life stories to an interested audience. Once developed, the project staff will undergo intensive training and implement the model with older adults. The project will be staffed with one clinician and three full-time equivalent community workers; the team will prioritize outreach efforts to the County's underseved cultural populations.

Outreach efforts will target isolated seniors by engaging social work organizations, physicians' offices, faith-based organizations, senior centers, senior apartment complexes through the use of announcements, flyers and local newspapers . Staff will make all attempts to contact family members or cargivers to participate in this activity. The clinician will provide clinical assessment and crisis intervention when required, attending in particular to elders such as refugees who may be exposed to reliving traumatic experiences. The clinician will also provide linkage services for clients requiring additional assessments, services or supports through the mental health system of care and and other social services.

Community workers will conduct twelve (12) weekly home visits to the senior. At the first two-hour visit, staff will conduct an assessment of the senior's quality of life, depressive symptoms and cognitive functioning. For clients who have little or no immediate family

support, program staff will work intensively from the first contact and throughout the 12-week program to identify family or other natural community-based supports to reduce the older adults' isolation in the long-term. At the first meeting, staff members meet with family members and caregivers, build rapport with the senior and explain roles and the process. Each following week, as the senior is elicited to reminisce about his/her life, listeners adopt an appreciative inquiry approach, looking for meaningful experiences that may lead to a more evolved understanding of how stories define the author and how he/she walks through the world. Life stories become a sourcebook of instructions for how to negotiate life's twists and turns. Stories can be used as a tool for deep reflection, for healing, or for the purpose of deep understanding of social changes, and cultural traditions. A few skillful touches can draw out messages of hope and optimism, enabling seniors to have an inspired outlook on life, inspire action and shape medical treatment.

The team then explores ways to capture and shape the oral histories into powerful presentations for families, communities, and cultures. Significant memories and personal accomplishments can be commemorated through various expressive arts techniques such as journaling, memory books, videography. There are a myriad of ways to tap into an ongoing creative meaning-making process. Seniors' special talents can be captured in the development of special project such as a recipe book of ethnic cuisine to leave for future generations. A young adult grandchild may lead the effort to script the story digitally, scan photographs and mementos and download digital symbolic images. Audio recordings and visuals can be put together using quick and easy storyboarding techniques, and stories can be published to a variety of platforms: CD, DVD, VHS, web. The family/team will become producers of multi-media, not just consumers. All of these final projects, developed as a way to honor the senior's life, will be kept by the senior for later reminiscing, sharing, and review. Members of the family will have developed shared memories that can be the basis for continuing activities together in the future.

In the last few weeks, the team explores ways to convene venues to present to and celebrate with the larger commuity. Stories help people remember the living threads that make communities whole. Communities, listening and telling together, enrich each other, become vaster, wiser, and more compassionate.

At project completion, the materials developed during the project can constitute innovative ways of disseminating the project results.

The project is consistent with MHSA general standards in the following ways.

Cultural Competence: The project adapts and builds upon the traditions and cultures of underserved communities. The project seeks to reduce disparities in access by hiring community workers who are culturally and linguistically competent in English, Spanish and Vietnamese. Members from the Ethnic and Cultural Advisory Committees (ECCAC) will help to outreach and case-find seniors from ethnic communitites, particularly those who are not connected to the public mental health system.

Integrated Service Experience: The project promotes an integrated service experience by employing a mental health clinician to work with community workers. The clinician will provide linkage services for clients requiring additional assessment, services, or supports from the mental health system of care. The twelve-week program will include planning to connect older adults to people, groups, services and other natural community-based supports to reduce their isolation in the long-term.

Consumer- and Family-Driven: The project invites and encourages the active participation of family members in the 12-week activity. A Learning Advisory Committee composed of consumers, other older adult stakeholders and family members will be convened to assess project progress, evaluate learning outcomes, plan for innovation sustainability if successful, and develop materials to communicate lessons learned and project results.

Community Collaboration
This project will develop linkages with social services organization, agencies working with seniors in particular with elderly abuse, public guardian office, senior centers, faith based organizations, medical clinics and physicians' offices to outreach and get referrals for isolated and vulnerable seniors into the program. Ethnic community workers will be trained and work in collaboration with clinicians to provide integrated case management and mental health services as needed. Program staff will also work intensively to identify family members/care-givers and connect the seniors with natural community-based supports in the hope to engage the senior in community activities and reduce isolation.

Wellness, Recovery, Resilience Focus: The project's most novel feature is the fact that it is grounded on a cultural tradition based on wellness, builds on the natural strengths of older adults and is a creative approach for the prevention of emergent mental illness. By supporting and acknowledging older adults' roles and importance in families and societies, the model intends to restore empowerment, hope and resilience in the client.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

This project adapts a strengths-based approach into the mental health system. The approach focuses and builds upon the traditional roles of older adults as transmitters of cultural and familial knowledge and wisdom. Through the articulation and conveyance of older adults' biographies, the project assists families and individuals in re-establishing the older adults' traditional roles as a means of mitigating emerging or existing mental health symptoms. Life review and life reminiscing techniques in individual and group settings have been studied and established to contribute to reducing depressive symptoms and improve quality of life among older adults.

This project's design brings three innovative elements. First, instead of clinicians, the project will use community workers who are competent in meeting the seniors' cultural and linguistic needs. Many older immigrants in Santa Clara County are not fluent in English. The hypothesis is that the cultural resonance and common language will facilitate the reminiscing and telling of personal distant stories.

Second, the community worker will make every effort to identify, engage, invite and include a family member/caregiver in the activity. This may contribute to greater interpersonal understanding and strengthened relationships. Family member participation will potentially generate further common activities, thus reducing the older adult's isolation.

Third, after the exercise of life reminiscing and telling, the community worker works with the family member and the senior to find a way to capture the story and look for venues for presentation to the larger community. The intent is to build further appreciate memories for the senior's life, and preserve personal and collective cultural history.

The learning questions are as follows:
Process Question 1. How does the utilization of a community worker with cultural competence contribute to the senior's comfort level in expressing his personal memories?

Process Question 2. How does the inclusion of a family member throughout the activity affect the relationship between the senior and the family member at the conclusion of the activity?

Process Question 3. How does the exercise of capturing the seniors' life stories through some expressive arts medium and presenting them to the larger community contribute

to preserving personal and collective history?

Outcome Question 1. How many older adults engage in this program?

Outcome Question 2. How does the program affect the seniors' quality of life and daily functioning?

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: NOV 2010 - OCT 2013
MM/YY – MM/YY

October 2010 – Approval from OAC

October 2010 – November 2010
- Establish Learning Advisory Committee (LAC) to refine project assessment plan including final success measures, data indicators and reporting infrastructure.
- Finalize project implementation plan, and write Request For Proposal.

December 2010 - January 2011
- Complete procurement process and hiring of new staff
- Convene initial LAC with project staff. Meetings will occur quarterly.

February 2011 - March 2011
- Complete story telling curriculum documentation, endorsed by LAC.
- Complete 12-week service model documentation, endorsed by LAC.
- Complete training of new staff.

April 2011
- Outreach and assessing referrals

May 2011 – August 2011
- Service implementation first cycle

September 2011 - December 2012
- LAC meeting to review first cycle implementation, process and outcome measurements, recommend changes as appropriate.
- Oureach and assess referrals for second cycle
- Service implementation second cycle

January 2012 – April 2012
- LAC meeting to review second cycle implementation, process and outcome measurements, recommend changes as appropriate.
- Outreach and assess referrals for third cycle
- Service implementation third cycle

May 2012 - August 2012

- LAC meeting to review third cycle implementation, process and outcome measurements, recommend changes as appropriate.
- Outreach and assess referrals for fourth cycle
- Service implementation fourth cycle
-

September 2012 - December 2012
- LAC meeting to review fourth cycle implementation, process and outcome measurements, recommend changes as appropriate.
- Outreach and assess referrals for fifth cycle
- Service implementation fifth cycle

January 2013 - April 2013
- LAC meeting to review ffifth cycle implementation, process and outcome measurements, recommend changes as appropriate.
- Complete follow up surveys
- Outreach and assess referrals for sixth cycle
- Service implementation sixth cycle

May 2013 - August 2013
- Complete evaluation by a contracted research provider, and dissemination of a final project report.
- Present draft project report with initial feasibility for sustaining, integrating or replicating project services or lessons learned to MHD staff, Mental Health Board and the Stakeholder Leadership Committee.

October 2013
- Complete services
- Complete evaluation by a contracted research provider, and dissemination of a final project report.

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an advisory capacity to the project staff for the life of the project. While the membership of each Learning Advisory Committee will be different, all Learning Advisory Committees will include consumers and/or family members, providers, system partners and MHD staff. When appropriate, existing stakeholder groups, committees or task forces will be utilized.

Facilitated and supported by MHD staff, each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members refine the program design, finalize the process and outcome measures, monitoring tools and reporting infrastructure. This will ensure that stakeholders, the MHD and project staff have clearly defined objectives and measurement tools.

Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and outcome data. In this role, stakeholders assist staff implement the project by advising on operational issues such as vetting data indicators, problem solving, reviewing reports and connecting clients to other services. The LAC continually assesses the project's progress toward the stated aim, and makes recommendations on how to modify services or activities if objectives (i.e. success measures) are not being achieved.

Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned. In this role, members help connect the project's contributions to the broader system(s) of care.

Final project reports and recommendations will be provided to system partners, the County's Stakeholder Leadership Committee, the Mental Health Board and the Board of Supervisors.

At this time, the following measures are proposed for each learning question:

Process Question 1. How does the utiltization of a community worker with cultural competence contribute to the senior's comfort level in expressing his personal memories?
Measures: Semi-open interview or survey about what personal characteristics or behaviors of the community workers contribute to facilitating the exercise of reminiscing and story telling.

Process Question 2. How does the inclusion of a family member throughout the activity affect the relationship between the senior and the family member at the conclusion of the activity?
Measures: Semi-open interview of the senior and family member about changes in feelings about the relationship, changes in number of activities engaged by the senior together with the family member

Process Question 3. How does the exercise of capturing the seniors' life stories through some expressive arts medium and presenting them to the larger community contribute to preserving personal and collective history?
Measures: Semi-open interview of the senior about the impact of this exercise on his sense of self and self in relationship with his community. Survey or focus group with participant community members about their perspective of the impact of these events on the community.

Outcome Question 1. How many seniors engage in this program?
Measure: Record number of older adults who are outreached, number of seniors who start and number of older adults who complete the program

Outcome Question 2. How does the program affect the seniors quality of life and daily functioning?
Measure: Pre- and post-surveys, and follow up after 6 and 12 months, to determine changes in:

a. Quality of life across several key life domains (emotional and spiritual health, supportive relationships, meaningful activities, physical health)

b. Depressive symptoms (mood, energy level, ability to think clearly , change in interest in activities, thoughts of death and suicide)

c. Cognitive functioning (executive functions, working memory, fluid reasoning, attentional capacity)

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

Partnerships will be established will local universities to explore the possibility of utilizing academic expertise to support the development of the new model.

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Santa Clara

Work Plan Name

Older Adults

Annual Number of Clients to Be Served (If Applicable)
180 Total

Population to Be Served (if applicable):

Isolated/homebound older adults (age 60 and over) including those from underserved ethnic communities with emergent or previously unrecognized mental health symptoms.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

Individuals over 60 years of age are who are isolated/homebound are at-risk for developing mental health symptoms, such as depression and cognitive decline, which can lead to serious mental illness and suicide. Underserved older adults from ethnic communities are more susceptible to isolation due to cultural and language barriers, and are more difficult to engage in mental health services.

This project develops a model to increase the quality of services for isolated older adults by adapting a culturally-based approach that capitalizes on the traditional role of older adults as transmitters of cultural wisdom and values. Targeted outreach efforts will be conducted through flyers, announcements and ethnic newspapers to current clients as well as those not known to any system of care, no formal mental health diagnosis is required. The core service will be provided by community workers through a 12-week curriculum where the older adult, in the company of family members and caregivers, is elicited to reminisce on his/her life and express and capture significant memories and personal accomplishments. These shared memories can be commemorated through various expressive arts techniques such as journaling, memory books, videography or digital stories. Venues will be explored to present, celebrate and honor the older adult's life with the larger community. Older adults needing further services will have access to clinical services and case management for linkages to natural community supports.

If successful, the project will provide a method of reducing older adults' depressive symptoms and cognitive decline that is low-cost, engages natural support systems, and can be easily incorporated into the current mental health services programming.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Santa Clara Fiscal Year: 2010/11

Work Plan #: INN-04

Work Plan Name: Older Adults

New Work Plan ☑

Expansion ☐

Months of Operation: 11/10- 6/11
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			156,042	$156,042
2. Operating Expenditures			56,018	$56,018
3. Non-recurring expenditures			40,000	$40,000
4. Training Consultant Contracts				$0
5. Work Plan Management				$0
6. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$252,060**	**$252,060**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$252,060**	**$252,060**

Prepared by: Jeanne Moral Date: 9/3/2010

Telephone Number: 408-885-6867

Budget Narrative

Fiscal Year 10-11

Note: All amounts represent annualized amounts for the first year of the project's operation.

Innovation Program: INN-04 – Older Adults

A. Expenditures

Personnel Expenditures:
Staffing expenses include salary and benefits for three community workers/trainers to provide program services and one licensed master's level project director to provide clinical and administrative oversight.

Operating Expenditures:
- General operating expenses (office supplies, phones, mileage, etc.) are calculated at 10% of personnel expenses.
- $30,000 is set aside for program materials to support the documentation of and/or transmission of clients' life histories, and to support other relevant cultural activities.
- Overhead expenses are calculated at 10% of total program expenses.

Non-Recurring Expenditures:
- $15,000 is set aside for the development of the program model and materials.
- $25,000 is allocated for the purchase of furniture, equipment and services associated with establishing the program.

B. Revenues
To be determined.

Innovation Work Plan Narrative

Date: 09/03/10

County: Santa Clara County

Work Plan #: INN-05

Work Plan Name: Multi-Cultural Center

Purpose of Proposed Innovation Project (check all that apply)

- ☒ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☐ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

The County's community planning processes continually highlight the severe challenges members of ethnic communities face in accessing and utilizing mental health services. Data from the County's CSS plan reveal that there are significant service disparities for individuals of color, especially Latinos and Asians, for all age groups.

Prior to passage of the MHSA, the County had achieved some progress in addressing the problem of underserved ethnic communities through policies aimed at increasing the number of culturally and linguistically competent mental health practitioners providing services to consumers. Then during implementation of the County's CSS plan, the Mental Health Department (MHD) assembled and funded Ethnic and Cultural Community Advisory Committees (ECCACs), which were families members and consumers from the African American, African descent, Chinese, Filipino, Native American, Latino, LGBTQ, Refugee and Vietnamese communities. These groups provided culturally competent outreach and support to ethnic consumers and families.

Despite these efforts, novel and innovative approaches are still needed. Preliminary data used to discern the County's progress on providing mental health services to unserved and underserved populations are inconclusive. Moreover, discussions with partners from ethnic communities reveal that most ethnic communities are unmoved by current mental health outreach and engagement efforts. Among many communities, there remains a strong mistrust of mental health treatment and providers. These seemingly impenetrable barriers are often fueled by severe stigma associated with having a mental illness and discrimination against people affected by mental illness. Unfortunately, often when an individual starts to engage, their fears are reinforced by mental health practices that seem non-welcoming and ineffectual at best; at worst, the services are perceived as counter cultural and not respectful of cultural values, including spiritual beliefs and the importance of family in treatment.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

The aim of this project is to increase access to underserved and inappropriately served ethnic communities, and to increase their access to mental health services.

For the last several years, the County has tried to engage ethnic and cultural communities by working with peer and family partners who were members of those communities (e.g. ECCACs). While they worked collaboratively, each member focused on his or her community. The project will offer multi-cultural services designed and delivered by peer and family partners in one site. This will provide an opportunity for ethnic community groups to collaborate in identifying and initiating multi-cultural approaches to successfully engaging individuals in mental health services, including prevention and early intervention.

The stakeholders and the MHD envision a community center that supports and promotes the health of underserved communities through culturally specific and multi-cultural mental health promotion, prevention and support activities provided by peers, family members, and community members.

The Multi-Cultural Center (MCC) will foster a new governance model grounded in ethnic traditions, synergy and inter-cultural learning stemming from collaboration among multiple ethnic groups, and provide deeper understanding for bridging ethnic cultures and the mental health system. The MCC will offer a welcoming, accessible and safe place where members of all ethnic communities can find a sense of cultural resonance, belonging and support. The MCC will be open to ethnic events and celebrations, creating a natural place for community members to congregate, and where conversations about mental well-being can be inserted and approached within appropriate cultural contexts and languages. Videos and life presentations of testimonials from ethnic community members recovering from mental illness can be shown to de-stigmatize the condition, discuss deep-seated cultural beliefs and reduce fear around using mental health services.

The MCC will support the activities of peer and family partners in the current ECCAC groups; however, the project will support the inclusion of members from all ethnic groups in the County. Significant effort will be made to inform the communities about the MCC's services. Some of these efforts will be a part of the ECCACs approved PEI and CSS strategies. Others will be developed as the communities come together and learn from one another.

Governance – The first step in this project is to assemble an advisory group composed of representatives of ethnic leaders who are passionate about mental well-being in their communities. At this time, the ECCAC governance is modeled after the Way of Council, a Native American tradition. The Way of Council core values of inclusivity, holism, and non-linear and non-hierarchical organization are embodied in the practice of “Talking Circles” where members of groups each have a chance to talk from the heart, learn from their own life experiences and share their personal feelings. The MHD will be challenged to facilitate the development a governance model that facilitates collaboration among many ethnic wisdoms while being compliant with the regulations that the MHD must follow. The advisory group will be a part of the Learning Advisory Committee.

Services – Designed by ethnic family members and peer mentors, engagement and support services will be delivered in a community-based, linguistically and culturally appropriate supportive setting. The intention is to make mental health a natural topic of conversation, thus combating severe stigma including internalized oppression. Services will likely include those of traditional healers and practitioners that have been shown to be beneficial and complementary to western methods. Experience has shown that many have tried healing methods from other ethnic groups such as acupuncture, sweat lodges, meditation, and found them to be very beneficial to their well-being. Some current ECCAC and cultural groups have expertise working with different populations such as newly released inmates and veterans. The grouping of services within the same site allows groups to learn from each other’s experience and provide services to these special groups in all ethnic languages.

The project is built on the following MHSA general standards:

Community Collaboration – The project fosters collaborative leadership and increased collaboration among ethnic communities and with the Mental Health system.

Cultural Competence – Implemented by ethnic family members and peer partners, services will be designed by each culture rather than imposing service onto communities from "outsiders." The intended collaboration will allow for continuous learning and ongoing cross-cultural understanding, for the specific pupose of increasing capacity to reduce disparities in access to mental health services and to improve outcomes.

Client and Family Driven Mental Health System - Clients and families are the main service providers and service recipients in this project. Together, they will take the lead in administering the MCC, run operations and create community events and activities which emphasize mental well-being. Community events are a great way for community members to disseminate information about mental health and about the Center to the larger communities.

Wellness, Recovery and Resilience Focus - MCC services will embrace, rely on, and harness the protective factors that are unique and shared among cultures in order to promote services/activities that contribute to mental well-being.

Integrated Service Experience - The project embraces healers and practitioners not traditionally defined as a part of mental health care, and creates a bridge between ethnic communities, ethnic services and the Mental Health system.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

This project introduces a new mental health practice approach of facilitating cross-cultural collaboration between ethnic communities in one center in order to increase access and engagement and improved quality of life for underserved individuals and their families. For the last several years, the County has tried to engage ethnic and cultural communities by working with peer and family partners who were members of those communities (e.g. ECCACs). While they worked collaboratively, each member focused on his or her community.

The project will offer multi-cultural services designed and delivered by peer and family partners in one site. This will provide an opportunity for ethnic community groups to collaborate in identifying and initiating multi-cultural approaches to successfully engaging individuals in mental health services, including prevention and early intervention. By concentrating ethnic-specific services at one site, the County and each community will be able to discern how different cultures address the day-to-day realities of mental health. Cultures can share their underlying beliefs about the causes of mental illness and find senstive ways to combat stigma and internalized oppression by observing and documenting how different groups experience mental distress, talk about symptoms, make sense of the disease, and provide relief and healing.

This is a complex project with a broad scope and the exciting challenge of bringing together diverse groups from various different cultures and perspectives. It will require much forethought to set upthe right infrastructure to create an effective bridge between cultures and between the various cultures and the MHD. San Bernadino County's Innovation proposal of a Holistic campus is similar in scope and purpose. This is a great opportunity to form a Learning Collaborative, where the counties can share strategies, successes and lessons learned.

At this time, the following learning questions are proposed:

Process Question 1. How do the common core values, governance model and /or leadership principles facilitate the inclusion and authentic collaboration of culturally diverse groups?

Process Question 2. How is the operation design conducive to various cultures coming together for mutual learning and synergistic effectiveness?

Outcome Question 1. How does the Multi-Cultural Center improve ethnic communities

access to services and quality of services?

Outcome Question 2. How does the Multi-cultural Center impact providers' (etnic peers and family members) satisfaction level in relation to work setting and quality of services?

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: NOV 2010 - OCT 2013
MM/YY – MM/YY

October 2010 – Approval from OAC

October 2010 – November 2010
- Establish Learning Advisory Committee (LAC) to project assessment plan including final success measures, data indicators and reporting infrastructure.
- Finalize project implementation plan.
- Write Request For Proposal

December 2010 - March 2011
- Complete procurement process and hiring of new staff
- Convene initial LAC with project staff. Meetings will occur quarterly.
- Complete a MCC governance model
- Complete an ethnic-grounded service program
- Complete an operations procedure manual
- Establish site

April 2011: Service implementation begins

July 2011 - July 2013: LAC quarterly meetings to review implementation, process and outcome measurements, recommend changes as appropriate

July 2013: Present draft project report with initial feasibility for sustaining, integrating or replicating project services or lessons learned to MHD staff, Mental Health Board and the Stakeholder Leadership Committee.

October 2014
- Complete services
- Complete evaluation by a contracted research provider, and dissemination of a final project report.

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an advisory capacity to the project staff for the life of the project. While the membership of each Learning Advisory Committee will be different, all Learning Advisory Committees will include consumers and/or family members, providers, system partners and MHD staff. When appropriate, existing stakeholder groups, committees or task forces will be utilized.

Facilitated and supported by MHD staff, each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members refine the project model and finalize process and outcome measures, monitoring tools and reporting infrastructure. This will ensure that stakeholders, the MHD and project staff have clearly defined objectives and measurement tools.

Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and outcome data. In this role, stakeholders assist staff implement the project by advising on operational issues such as vetting data indicators, problem solving, reviewing reports and connecting clients to other services. The LAC continually assesses the project's progress toward the stated aim, and makes recommendations on how to modify services or activities if objectives (i.e. success measures) are not being achieved. For this project, the LAC will also consist of leaders and representatives of ethnic communities to help guide the development of the MCC, and to help staff resolve inter-cultural differences and tensions.

Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned. In this role, members help connect the project's contributions to the broader system(s) of care.

Final project reports and recommendations will be provided to system partners, the County's Stakeholder Leadership Committee, the Mental Health Board and the Board of Supervisors.

The following project measures are proposed for each learning question:

Process Question 1. How do the common core values, governance model and /or leadership principles facilitate the inclusion and authentic collaboration of culturally diverse groups?

Measures: Survey and focus groups of providers on the impact of the governance model on their comfort level in cooperating with other cultural groups, the level of cooperation and the impact of that cooperation on provided services.

Process Question 2. How is the operation design conducive to various cultures coming together for mutual learning and synergistic effectiveness?
Measure: Survey and focus groups of providers on the impact of the Center policies and operations on opportunities for cooperation, spirit of collaboration among providers of diverse ethnic origins, and the impact on clients and quality of services.

Outcome Question 1. How does the Multi-Cultural Center improve ethnic communities access to services and improve quality of services?
Measures: Document number of individual/families visits to the center. Survey visitors with questions on their satisfaction level in relation to the Multi-Cultural Center, the peer providers and the services received. Document number of clients who decided to access clinical mental health services after having visited to the Center.

Outcome Question 2. How does the Multi-Cultural Center impact providers‘ (ethnic peers and family members) satisfaction level in relation to work setting and quality of services?
Measures: Document number of providers working at the Center. Survey providers on their satisfaction level in relation to work setting (opportunites for empowerment, effectiveness level, etc) and quality of services (appropriateness, accessibility to diverse communities, etc)

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

The MCC will also be the site for the ECCACs, which are currently funded with CSS and PEI funds.

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Santa Clara

Work Plan Name

Multi-Cultural Center

Annual Number of Clients to Be Served (If Applicable)
1500 Total

Population to Be Served (if applicable):

Un-served and underserved ethnic community members including African, African-American, American Indian/Alaskan Native, Asian, and Latino.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

Ethnic groups face serious barriers (language, culture, severe stigma, etc) in access to mental health services. In Santa Clara County, data reveal significant disparities in service among ethnic and cultural populations especially Asians and Latinos.

The project develops a model to increase access to underserved and inappropriately served ethnic communities by establishing a Multi-Cultural Center/MCC designed to house activities and services for multiple ethnic communities. The MCC will offer a welcoming, accessible and safe place where members of all ethnic communities can find a sense of cultural resonance, belonging and support. The MCC will be open to ethnic events and celebrations, creating a natural place for community members to congregate, and where conversations about mental well-being can be inserted and approached within appropriate cultural contexts and languages. Designed and delivered mainly by ethnic family members and peer mentors, mental health promotion and support services will be grounded in ethnic traditions, and will incorporate healing methods and practices not currently in the system of care. Close collaboration among different ethnic groups engenders synergy and provides opportunities for deep cross-cultural learning. Services will be designed to combat stigma and facilitate bridging of traditional healing practices with existing mental health services.

If successful, this project will demonstrate how the inclusion of multi-cultural services in one setting can facilitate an innovative cross-cultural collaboration between ethnic communities and with the mental health system, resulting in increased capacity and services with higher receptivity levels. It will inform and guide efforts to increase the capacity of new immigrant populations in support of those with mental health issues.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Santa Clara Fiscal Year: 2010/11

Work Plan #: INN-05

Work Plan Name: Multi-Cultural Center

New Work Plan ☑

Expansion ☐

Months of Operation: 11/10- 6/11
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			144,387	$144,387
2. Operating Expenditures			262,404	$262,404
3. Non-recurring expenditures			75,000	$75,000
4. Training Consultant Contracts				$0
5. Work Plan Management				$0
6. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$481,791**	**$481,791**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$481,791**	**$481,791**

Prepared by: Jeanne Moral Date: 9/3/2010

Telephone Number: 408-885-6867

Budget Narrative

Fiscal Year 10-11

Note: All amounts represent annualized amounts for the first year of the project's operation.

Innovation Program: INN-05 – Multi-Cultural Center

A. Expenditures

Personnel Expenditures:
Staffing costs include the salary and benefits for a 2.8 FTE Facility Coordinators to coordinate facility issues and to ensure that the Center can be operated on evenings and weekends. Costs also include 1.0 FTE Activities Director to help coordinate and support the activities of peer partners, family partners and community members from the County's ethnic communities.

Operating Expenditures:

- General operating expenses (office supplies, phones, mileage, etc.) are calculated at 10% of personnel expenses.
- Facility expenses, including leasing and maintenance, are calculated at $2.50 per square foot per month. It is estimated that the site would be approximately 10,000 square feet ($300,000 annually).
- $50,000 is set aside for culturally relevant program materials, food and supplies.
- Overhead expenses are calculated at 10% of total program expenses.

Non-Recurring Expenditures:
$75,000 is allocated for one-time technical improvements, furniture and equipment.

B. Revenues
To be determined.

Innovation Work Plan Narrative

Date: 09/03/10

County: Santa Clara

Work Plan #: INN-06

Work Plan Name: Transitional Mental Health Services for Newly Released County Inmates

Purpose of Proposed Innovation Project (check all that apply)

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☐ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☒ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

The Santa Clara County Department of Correction website indicates that each year, approximately 65,000 arrestees are booked. Their average length of stay is about 110 days, and 80% of the population has a history of drug or alcohol related problems. The Bureau of Justice Statistics reported in 2006 that nationally 64% of jail inmates had a recent mental health problem. County statistics mirror national profiles indicating that ethnic communities are over-represented in the jails:

- Latino adults are 23.1% of the adult population and yet they are 52.2% of the county daily jail population.
- People of African descent are 2.7% of the adult population and comprise 12.9% of the daily adult jail population.

Existing services and supports available through the Santa Clara County mental health system of care to help newly released inmates are severely strained. Community faith organizations are attempting to aid with re-entry efforts but their efforts are fragmented and their effectiveness is hampered by a lack of coordination and support from County agencies with jailing or treatment obligations to the population.

The result is that there are a significant number of newly released inmates who receive no help at all and experience prolonged suffering including frequent reincarceration. County inmates are frequently released to the community without sufficient community resources or supports. As a result they are very likely to experience avoidable suffering and poor life outcomes due to lack of mental health services, social disruption, substance abuse related problems, lack of adequate housing and lack of financial and social support to successfully adjust to community living. Families, children, and communities also suffer from the effects of loved ones being incarcerated and unable to provide for their emotional, cultural, and financial needs.

One strength of the County is that faith communities are attempting to help newly released inmates. However, fragmentation and systemic problems related to re-entry for inmates limit the capacity and effectiveness of faith-related groups and initiatives to serve the population. During the community planning for the development of this Innovation project, faith-based, consumer, and other concerned stakeholders identified several key barriers to providing effective outreach to newly released inmates:

• The lack of coordination between providers and volunteer groups currently serving this population;

• The lack of in-reach opportunities in county jails to make connections with inmates in order to assist them with discharge planning prior to their release; and,

• The lack of knowledge about how to work effectively with the newly released inmates.

Consumers stated that they had difficulty accessing necessary services and supports due to the lack of discharge planning and poor coordination between service providers. They also highlighted problems they had accessing dual diagnosis drug/alcohol and mental health treatment programs.

Research supports the finding that faith-related community-based efforts to effectively serve the population is hindered by their limited organizational capacity to overcome systemic barriers and coordinate services. To be effective, faith-based efforts must match clients with appropriate agencies and work closely with other entities who provide services. In addition, the organizations need to have coordinated outreach and discharge planning. Considerable effort and planning are needed to be effective. Many faith-based entities or initiatives lack the organizational capacity to accomplish these goals.

There is no existing model that the County can use to address this critical barrier. For this reason, the County is proposing the development of a new one. The MHD can help to address the identified barriers by formally establishing and recognizing partnerships with faith-based organizations, assisting in the coordination of integrated services, providing training and education, and supporting of access for discharge planning, connections to other service providers and other in-kind supports. If factors related to systemic barriers to treatment and the lack of organizational capacity are addressed through the project, faith organizations may be well positioned to respond quickly and effectively to newly released inmates and their family members with outreach due to their proximity, flexibility, and lack of restrictive eligibility and program requirements. They may also be uniquely well-positioned to increase positive outcomes for the population by reconnecting the newly released inmate to a faith community at the inmate's request.

NOTE: No inmates requesting assistance through the project will be required to receive support from any one faith community and will not be required to participate in any religious/faith activities to receive support/assistance through the project.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

The aim of this project is to develop a model that will increase access to services and improve outcomes for newly released county inmates with mental health needs through an innovative collaboration between the Mental Health Department (MHD), faith communities, and other service providers/advocacy groups concerned about this underserved population. Innovation provides an opportunity to learn about how to improve re-entry efforts for newly released inmates by testing whether recognition and support from the MHD and collaboration with other service providers and advocacy groups enables faith organizations to expand their capacity and improve their effectiveness.

This project differs from other faith-based re-entry projects because it addresses organizational deficits that research has identified is a barrier to effective service delivery. Organizational support from the MHD, increased coordination among diverse faith communities, and concentrated efforts to remove systemic barriers is expected to increase access to services for newly released County inmates.

The MHD will support the development of a multi-faith collaborative and provide training and other supports to its members. Members of the multi-faith collaborative will coordinate their efforts and align with other groups/initiatives working with this population. Specifically, the MHD, in conjunction with other collaborative partners/service providers will provide support for the development of an infrastructure for faith-based organizations to coordinate their efforts and reach out to inmates through discharge planning.

Although the adapted model being tested will be modified througout the life of the project based on ongoing learning and assessment, the MHD will generally provide the following organizational support: staff support for the interfaith collaborative, training, in-reach access to county jails for discharge planning, and flex funds.

A coorindator will be hired to develop, expand and organize an inter-faith collaborative. The coordinator will also be responsible for developing a comprehensive resource guide/map, working with collaborative members to improve coordination and deployment of resources.

The coordinator will also organize or deliver training and technical assistance to the collaborative members and their consitituents. Faith organization stakeholders expressed the need for trainings related to the following topics:

1. Effective "helping" and role/boundary setting with released inmates;
2. Mentoring practices that emphasize the development of social competencies through consumers establishing social relationships and organizational ties;
3. Mental health and substance abuse problems that result in functional impairments in occupational, community, health, and social relational domains;
4. Approaches to advocacy and the provision of support that result in successful system navigation and service linkages; and.
5. Helping faith partners and consumers identify and articulate their experiences about gaps in services and needed supports.

The MHD will work with the collaborative and with system partners to improve linkages between inmates and service providers. The MHD will also support the interfaith collaborative's efforts to join an existing in-reach discharge planning initiative developed by Destination Home (a local initiative to end homelessness).

Finally, the project will distribute flex funds to support individuals with immediate needs upon discharge from jail.

The project is consistent with the following MHSA General Standards:

Community Collaboration - The project achieves its purpose of increasing access to services for newly released inmates by initiating linkages between faith providers and the MHD and other broad initiatives to serve this population. This innovation project promotes systemic change to improve life outcomes of newly released county inmates by supporting the development of a multi-faith collaborative committed to working with this population and linking it to a broader county-wide reentry initiative.

Client- and Family-Driven Mental Health System - The project Includes consumers in program planning and project evaluation as well as dissemination of lessons learned. One of the Mental Health Department's training components to be offered to interfaith collaborative members will address the importance of strengthening relationships with family members when possible and increasing knowledge of resources related to coping with effects of incarceration and re-entry. In addition, family perspectives will be included through representation in the learning community activities including project evaluation and dissemination of lessons learned.

Wellness, Recovery and Resilience Focus - The project promotes wellness by offering a voluntary, flexible, supportive approach with a focus on connecting the former inmates to natural supports in their communities.

Integrated Service Experience - One initiative the multi-faith collaborative will align with is the Discharge Planning Committee of Destination Home in their efforts to develop a mechanism for in-reach access to the jails to do discharge planning with inmates prior to their release from jail. Moreover, the project establishes more formal connections between the MHD resources and other service provider/ advocacy group partners,

including training and technical assistance, to equip faith organizations with knowledge and supports to serve inmates re-entering the communities.

Cultural Competency - The project addresses diversity of faith/religious preferences through efforts to invite participation by a broad representation of faith communities that mirror the population's demographics and spiritual and cultural needs.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

This Innovation project adapts and strengthens a current practice of faith organizations attempting to assist newly released inmates through Mental Health Department (MHD) support that enables them to build their organizational capacity and assist them to coordinate with other faith communities and connect with other service providers/advocacy groups. The project examines whether the collaboration between the MHD, an inter-faith collaborative, and other service providers/advocacy groups increases the capacity of faith organizations to serve newly-released inmates and improve outcomes (symptom management; relationships; work/meaningful activities; and satisfaction with service.

If successful, this project will demonstrate how collaboration between faith organizations, volunteers, the mental health department, and other service providers/advocacy groups can play a role in increasing the community's capacity to support and facilitate successful re-entry of newly released inmates with mental health needs. The project will:

1. Identify supports and training that are effective in expanding the capacity of faith-based organizations to increase access to services for newly released county inmates;

2. Demonstrate how increased coordination and shared responsibility between stakeholder groups can result in more efficient deployment of existing resources and increased capacity to serve greater numbers of the affected population with better outcomes; and,

3. Demonstrate how low-cost efforts to remove systemic barriers to treatment can result in improved client outcomes.

Additionally, the project will contribute to learning by providing insight into whether and which elements of the adapted model succeeded in expanding the capacity and effectiveness of faith organizations through the following process learning questions:

Process Question 1. How does the formation of an interfaith collaborative affect the capacity of faith organizations?

Process Question 2. Which supports (e.g. training) provided by the MHD enabled faith organizations to expand capacity or increase effectiveness?

Process Question 3. How does support from the MHD affect coordination between faith organizations and between faith organizations and service providers?

The following outcome learning questions will also be considered in determining success of the project:

Outcome Question 1. What is the impact for individuals served through the project of being connected with faith organizations?

Outcome Question 2. Are more individuals re-entering the community being served?

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: NOV 2010 - OCT 2013
MM/YY – MM/YY

October 2010 – Approval from OAC

October 2010 – December 2011
- Establish Learning Advisory Committee (LAC) to refine project assessment plan including final success measures, data indicators and reporting infrastructure.
- Hire/procure a coordinator to recruit, organize and support members of the interfaith collaborative.
- Finalize project implementation plan and service model.
- Establish interfaith collaborative.

January 2011 - March 2011
- Map existing resources and develop a plan for better coordination and deployment of resources to meet the need
- Develop and provide training and support to build capacity of collaborative members.
- Begin outreach/in-reach efforts to inmates.

March 2011 - April 2013 - Convene learning advisory committee to conduct quarterly reviews and monitor programs for progress towards learning goals (1) Collect, compile, review, and assess data (2) recommend changes and adjustments to the project model (3) initiate discussion about how project will be sustained if successful through alternative funding sources or system transformation (4) Discuss and make recommendations for how learning results from project will be communicated/shared.

July 2013 - Present draft project report with initial feasibility for sustaining, integrating or replicating project services or lessons learned to MHD staff, Mental Health Board and the Stakeholder Leadership Committee.

October 2013 - Issue final report.

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an advisory capacity to the project staff for the life of the project. While the membership of each Learning Advisory Committee will be different, all Learning Advisory Committees will include consumers and/or family members, providers, system partners and MHD staff. When appropriate, existing stakeholder groups, committees or task forces will be utilized.

Facilitated and supported by MHD staff, each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members finalize project success measures, monitoring tools and reporting infrastructure. This will ensure that stakeholders, the MHD and project staff have clearly defined objectives and measurement tools.

Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and outcome data. In this role, stakeholders assist staff implement the project by advising on operational issues such as vetting data indicators, problem solving, reviewing reports and connecting clients to other services. The LAC continually assesses the project's progress toward the stated aim, and makes recommendations on how to modify services or activities if objectives (i.e. success measures) are not being achieved.

Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned. In this role, members help connect the project's contributions to the broader system(s) of care.

Final project reports and recommendations will be provided to system partners, the County's Stakeholder Leadership Committee, the Mental Health Board and the Board of Supervisors

The process learning questions will be assessed with the following measures:

Process Question 1. How does the formation of an interfaith collaborative affect the capacity of faith organizations?
Measure: Documented number of faith organizations and other service providers and advocacy groups engaged in the collaborative.

Process Question 2. Which supports (e.g. training) provided by the MHD enabled faith organizations to expand capacity or increase effectiveness?
Measure: Surveys assessing satisfaction levels of faith organizations with organizational supports provided through the project.

Process Question 3. How does support from the MHD affect coordination between faith organizations and between faith organizations and service providers?
Measure: Documented number of referrals for services between faith organizations and other service providers

Outcome Question 1. What is the impact for individuals served through the project of being connected with faith organizations?
Measures: Documented measure of newly released individuals functional change in:
- symptom management, quality of relationships, and work/meaningful activities per measurement tool endorsed by LAC;
- Documented reincarceration or recidivism rates of individuals served through the project; and,
- Surveys of satisfaction levels of client and/or family satisfaction with program model as per tool endorsed by LAC.

Outcome Question 2. Are more individuals re-entering the community being served?
Measures: Documented number of newly released inmates being served through the project against baseline of the number of county inmates receiving with re-entry services before the project.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

- Existing programs/outreach of faith-based organizations that opt to join the inter-faith collaborative

- Service providers and advocacy groups who contribute resources to the project

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Santa Clara

Work Plan Name

Transitional Mental Health Services to Newly Released County Inmates

Annual Number of Clients to Be Served (If Applicable)
75-125 Total

Population to Be Served (if applicable):

Newly released county inmates with mental health conditions or who are at risk for the development of mental health/substance abuse conditions.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The aim of this 36-month project is to develop a model that examines whether the organizational support of the Mental Health Department provided to an inter-faith collaborative and coordination and collaboration with other service providers/advocacy groups increases the capacity of faith organizations to serve newly-released inmates and improve outcomes (symptom management; relationships; work/meaningful activities; and satisfaction with service).

The project involves:
(1) the development of a service that is informed and designed through collaboration between consumer/family members, faith communities, the Mental Health Department, and other service providers/advocacy groups;
(2) the development of an engagement and treatment approach that emphasizes the MHSA general standards of service integration and wellness and recovery principles;
(3) the development of a sustainable approach designed to increase capacity through coordination for more efficient use of existing resources, and collective responsibility for achieving desired outcomes; and,
(4) the voluntary connection of inmates with faith organizations/volunteers who will offer social, emotional, spiritual support as well as advocacy and linkage to access available community resources.

If successful, this project will demonstrate how collaboration between faith organizations, volunteers, the mental health department, and other service providers and advocacy groups can play a role in increasing the community's capacity to support and facilitate successful re-entry of newly released inmates with mental health needs.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Santa Clara Fiscal Year: 2010/11

Work Plan #: INN-06

Work Plan Name: Transitional MH Services to Newly Release Inmates

New Work Plan ☑

Expansion ☐

Months of Operation: 11/10- 6/11
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			81,667	$81,667
2. Operating Expenditures			174,358	$174,358
3. Non-recurring expenditures				$0
4. Training Consultant Contracts				$0
5. Work Plan Management				$0
Expenditures	**$0**	**$0**	**$256,025**	**$256,025**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$256,025**	**$256,025**

Prepared by: Jeanne Moral Date: 9/3/2010

Telephone Number: 408-885-6867

Budget Narrative

Fiscal Year 10-11

Note: All amounts represent annualized amounts for the first year of the project's operation.

Innovation Program: INN-06 – Transitional Mental Health Services to Newly Released County Inmates

A. Expenditures

Personnel Expenditures:
Staffing costs include salary and benefits for a full-time project coordinator with clinical skills to develop the inter-faith collaborative and provide ongoing consultation, training, and support to faith providers in their work with newly released inmates.

Operating Expenditures:

- General operating expenses (office supplies, phones, mileage, etc.) are calculated at 10% of personnel expenses.
- $200,000 is allocated to faith providers to support their work with inmates including stipends, flex funds, and other costs.
- Overhead expenses are calculated at 10% of total program expenses.

Training Consultant Contracts:
$45,000 is allocated to contracts with area specialists for training and for materials associated with training and supporting providers.

B. Revenues

To be determined.

Innovation Work Plan Narrative

Date: 09/03/10

County: Santa Clara

Work Plan #: INN-07

Work Plan Name: Mental Health & Law Enforcement Post Crisis Intervention

Purpose of Proposed Innovation Project (check all that apply)

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

The project will provide immediate, compassionate, post-crisis intervention by a culturally competent team comprised of a peer/family advocate and a clinician to individuals and families who experience a law enforcement involved mental health and/or suicide related event. The project will improve mental health crisis resolution, service engagement and outcomes, as well as improve interagency collaboration.

Law enforcement is regularly called to respond to community members experiencing acute mental health crises. During FY 09-10 Santa Clara County law enforcement agencies were dispatched to 4301 events classified as 5150s (mental health calls) or 1056s (suicide related calls). The National Alliance on Mental Illness (NAMI) actually estimates that 10% of law enforcement calls for response relate to individuals and their families experiencing an acute mental health crisis. Many law enforcement experts suggest that the actual percentage is significantly higher.

Traditionally when law enforcement officers respond to these types of events, their first priority is to determine whether the subject meets the requirements for a 5150 hold. If the subject does meet these requirements, the subject is transported to Emergency Psychiatric Services (EPS). The officer completes a report and returns to service. If the subject does not meet the criteria for a 5150 hold, under ideal circumstances (e.g., a CIT officer) the officer may provide resource material, make a referral or transport willing individuals to Mental Health Urgent Care on a voluntary basis. The officer then returns to service and generally, no follow up occurs. Currently, there is no accepted protocol for law enforcement agencies to share information about mental health crisis responses with the actual mental health system. As a result, law enforcement often returns to address repeated crises at the same locations, involving the same people, and the mental health system remains an unaware and untapped resource. Law enforcement repeat responses many times result in unnecessary hospitalizations, incarcerations and use of force, including officer involved shootings.

A recent study of officer involved shootings in Santa Clara County revealed that of the 22 shootings that occurred in a five-year period, ten of the shootings involved people who were mentally ill.

For years Santa Clara County has been implementing programs to improve the quality of law enforcement responses and outcomes for the individuals in mental health crises (e.g. Crisis Intervention Team Training, Roll Call Trainings, Law Enforcement Liaisons and Mental Health Urgent Care). Yet local stakeholders and law enforcement officials agree that there is a serious need for continued improvement. Two of the primary shortcomings of the current system are: (1) lack of inter-agency communication and collaboration, and (2) a collective failure to engage individuals and families into effective treatment services immediately after a crisis event, resulting in failure to access available services, and a range of negative consequences including avoidable suffering, multiple hospitalizations, repeated law enforcement responses, the use of force, and unnecessary incarceration.

While some of the individuals who have an acute crisis have received mental health services (public or private), it is unclear exactly how many have had treatment and how many seek first-time or follow-up mental health services after a crisis. Based on estimates of repeat emergency responses, law enforcement professionals posited that many individiuals do not seek services after the initial response either because of stigma, the lack of information about available services or misconceptions about mental illness. Poor engagement may also be attributal to cultural and linguisitic barriers (the County has large populations of immigrants).

Consumers and family members agree that responding to people with mental health crises poses significant risk and challenges for law enforcement, and that repeated responses strain limited resources. Consumers and family members also strongly support solutions that will: infuse more compassion into the process during and after crisis events; address cultural barriers and fear of law enforcement; engage consumers and family members in appropriate mental health services after crises have occurred; and, significantly, include consumer/family partners.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

Slightly over half the population of Santa Clara County lives in the City of San Jose. San Jose also generates roughly half of the law enforcement dispatches to metal health and suicide related calls in the County (1996 events in FY 09-10). San Jose was therefore selected as the test site for this project. The project design calls for the San Jose Police Department (SJPD) to provide dispatch data regarding all mental health and suicide related events to mental health post-crisis response teams, on a daily basis. Within twenty-four hours after the crisis event, the post response teams, comprised of a family/peer advocate and a mental health clinician, will meet with individuals and/or families to whom law enforcement has recently responded.

The teams will serve the total San Jose community and all ethnic and cultural groups therein, however due to the high prevelance of Spanish and Vietnamese speakers in San Jose, team members will be recruited and selected to meet linguistic and cultural needs of Vietnamese and Hispanic clients. Current plans call for the creation of two post response teams, each consisting of a peer/family advocate and a clinician. Hiring consumers and family members in paid positions is an intrinsic element of the plan. The two teams will be deployed on a schedule that provides 7 day coverage, during peak hours of effectiveness.

Following the police response, the teams will provide immediate (within 24 hours) follow-up to families, through phone calls and home visits, to listen to their concerns, and to share information about available treatment and resources. The project goal is to immediately connect the individual/family to effective, culturally appropriate mental health services and supports based on their individual needs. The County will measure the extent to which this approach impacts repeat police responses and increases access to services. Project staff will conduct frequent debriefings with the Learning Advisory Committee, mental health law enforcement liaisons, ethnic and cultural advisory committees, consumer/family members and clinical staff to continually improve the effectiveness in providing timely compassionate interventions, focused on wellness and recovery. The Learning Advisory Committee will include consumers and family members who reflect the rich ethnic and cultural diversity of our community.

This project is consistent with the following Mental Health Service Act general standards:

Community Collaboration - This project includes significant collaboration between consumers, families, ethnic and cultural advisory committees, law enforcement, mental health providers and the County Mental Health Department.

Cultural Competence - The two teams will have the requisite linguistic and cultural competencies to effectively work with Vietnamese and Hispanic communities.

Client and Family Driven Mental Health System - Peer and family partners will form one half of the outreach teams and will be essential members of the Learning Advisory Committees. The project relies heavily on their experiences to engage and assist individuals and families, and to help guide the project.

Integrated Service Delivery - The project will increase access to various services and supports, by providing immediate, culturally competent, post-crisis assessment and referral services. In essence, project teams will function as mobile one-stop assessment and referral services.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

The project creates a new application of an existing practice, i.e., Mobile Crisis Response which exists in a number of California communities. The project differs from traditional MCR models however, in that the project calls for deploying culturally competent, bi-lingual teams comprised of a peer/family advocate and a mental health clinician to provide immediate, compassionate post-crisis response to consumers and family members who have experienced a law enforcement involved mental health or suicide related crisis. The project tests the impact of post-crisis response on consumer and family service engagement, improved outcomes for consumers and families, and a commensurate reduction in the need for repeat law enforcement interventions.

The project includes two innovative elements: (1) the creation of a heretofore non-existent, structured line of communication between law enforcement and mental health, that identifies mental health and suicide related calls for service, and creates the potential for mental health outreach teams to engage individuals and families who are currently falling through the cracks; and, 2) the creation of unique, culturally competent outreach teams, each comprised of a peer/family advocate and a clinician, working together to provide timely (within 24 hours), compassionate, post-crisis interventions and improve service engagement and outcomes for individuals and families.

Successful demonstration of the post-crisis response model will create the potential for County-wide expansion. Specific learning questions addressed by the project include:

Process Question 1: How does a new collaboration between mental health and law enforcement that structures information sharing regarding law enforcement responses to mental health crisis, contribute to the provision of immediate systematic post-crisis responses to individuals and families in need?

Process Question 2: How does the immediate deployment of culturally competent teams comprised of peer/family advocates and mental health clinicians, contribute to the provision of timely, compassionate outreach to consumers and families who have experienced a mental health crisis?

Outcome Question 1: Using historical law enforcement response data as a baseline for comparison, what is the effect of immediate, compassionate, culturally competent post crisis intervention on repeat law enforcement responses and response dispositions?

Outcome Question 2: What is the effect of immediate, compassionate, culturally

competent post crisis intervention on individuals and families who have been involved in a law enforcement related mental health crisis?

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: NOV 2010 – OCT 2012
MM/YY – MM/YY

October 2010 – Approval from OAC

October 2010 – November 2010
- Establish Learning Advisory Committee (LAC) to refine project assessment plan including final success measures, data indicators and reporting infrastructure.
- Finalize project implementation plan and service model.
- Issue Request For Proposal.

Dec 2010 - March 2011
- Complete RFP process and award contract
- Hire and train staff per model

April 2011 - Begin program services

July 2011 - April 2012: Convene learning advisory committee to conduct quarterly reviews and monitor programs for progress towards learning goals (1) Collect, compile, review, and assess data (2) recommend changes and adjustments (3) initiate discussion about how project will be sustained if successful through alternative funding sources or system transformation (4) Discuss and make recommendations for how learning results from project will be communicated/shared.

July 2012 - Present draft project report with initial feasibility for sustaining, integrating or replicating project services or lessons learned to MHD staff, Mental Health Board and the Stakeholder Leadership Committee.

October 2012 - Issue final report

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an active advisory capacity to the project staff for the life of the project. While the membership of each Learning Advisory Committee will be different, all Learning Advisory Committees will reflect our County's cultural diversity, and will include consumers and/or family members, providers, system partners and MHD staff. When appropriate, existing stakeholder groups, committees or task forces will be utilized.

Facilitated and supported by MHD staff, each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members finalize project success measures, monitoring tools and reporting infrastructure. This process will ensure that stakeholders, the MHD and project staff have clearly defined objectives and measurement tools.

Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and outcome data. In this role, stakeholders help staff implement the project by advising on operational issues such as vetting data indicators, problem solving, reviewing reports and connecting clients to other services. The LAC continually assesses the project's progress toward the stated aim, and makes recommendations on how to modify services or activities if objectives (i.e. success measures) are not being achieved.

Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned. In this role, members help connect the project's contributions to the broader system(s) of care.

Final project reports and recommendations will be provided to system partners, the County's Stakeholder Leadership Committee, the Mental Health Board and the Board of Supervisors.

The following measurement criteria are proposed for each learning question:

Process Question 1: How does a new collaboration between mental health and law enforcement that structures information sharing regarding law enforcement responses to mental health crisis, contribute to the provision of immediate systematic post-crisis responses to individuals and families in need?

Process Question 1 Measures: Track crisis calls data accuracy and appropriateness, and timing of compassionate team response.

Process Question 2: How does the immediate deployment of culturally competent teams comprised of peer/family advocates and mental health clinicians, contribute to the provision of timely, compassionate outreach to consumers and families who have experienced a mental health crisis?

Process Question 2 Measures: Multi-lingual survey of individuals and families about the timeliness of the team's response, and the team's behaviors and characteristics that contribute to an effective, culturally sensitive and compassionate response.

Outcome Question 1: Using historical law enforcement response data as a baseline for comparison, what is the effect of immediate, compassionate, culturally competent, post-crisis intervention on repeat law enforcement responses and response dispositions?

Outcome Question 1 Measures: Track number of times San Jose PD dispatches officers to repeat "5150" (mental health) or "1056" (suicide related) events during the target period compared to a control period. Track San Jose PD response dispositions during the target period compared to a control period. Track number of hospitalizations, incarcerations and police use of force during the target period compared to a control period.

Outcome Question 2: What is the effect of immediate, compassionate, culturally competent post crisis intervention on individuals and families who have been involved in a law enforcement related mental health crisis?

Outcome Question 2 Measures: Track project outreach team responses resulting in immediate, on-scene assessment and consultation. Track project team responses resulting in referrals to appropriate service providers. Track the levels at which consumers and families remain engaged in services. Conduct long term tracking of outcomes and recovery for individuals and families contacted.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

Ethnic Cultural Community Advisory Committee (ECCAC) has offered to provide staff with linguistic and cultural capacities to assist in outreach efforts.

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Santa Clara

Work Plan Name

Mental Health / Law Enforcement Post Crisis Intervention

Annual Number of Clients to Be Served (If Applicable)
1700 Total

Population to Be Served (if applicable):

Consumers experiencing mental health related crises to whom law enforcement have responded.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

Law enforcement is often called to respond to community members experiencing acute mental health crises. A failure to engage these individuals and their families into effective treatment services after a crisis results in avoidable suffering and a range of consequences including a deterioration in individual mental health and subsequent repeated use of emergency mental health services and highly restrictive law enforcement.

The aim of this project is to develop a model to improve mental health crisis resolution and engagement in services for these individuals and their families through the provision of compassionate and timely post-crisis services. The project will include:

1. Post-event visits (within 24-hours) from a team that includes a peer/family mentor and mental health clinician to offer support and education about services;
2. Follow-up support and linkage services as needed to assure resolution of mental health crisis and connection of client and family to needed services; and,
3. De-briefing with law enforcement liaisons, consumer/family mentors and clinical staff to continually improve operations effectiveness in providing compassionate and wellness/recovery focused support and linkages to appropriate services.

The project is expected to provide qualitative and quantitative data about service engagement and outcomes for those community members to whom police and mental health resources are deployed. It provides a unique opportunity for individuals and families in crisis to provide input about what they consider to be most helpful to them before, during and after mental health crises. This information guides future programmatic and policy responses.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Santa Clara Fiscal Year: 2010/11

Work Plan #: INN-07

Work Plan Name: MH / LE Post Crisis Intervention

New Work Plan ☑

Expansion ☐

Months of Operation: 11/10- 6/11
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			191,771	$191,771
2. Operating Expenditures			68,438	$68,438
3. Non-recurring expenditures			25,000	$25,000
4. Training Consultant Contracts				$0
5. Work Plan Management				$0
6. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$285,209**	**$285,209**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$285,209**	**$285,209**

Prepared by: Jeanne Moral Date: 9/3/2010

Telephone Number: 408-885-6867

Budget Narrative

Fiscal Year 10-11

Note: All amounts represent annualized amounts for the first year of the project's operation.

Innovation Program: INN-07 – Mental Health / Law Enforcement Post-Crisis Intervention

A. Expenditures

Personnel Expenditures:
Staffing costs include salary and benefits for two full-time mental health clinicians and for two full-time family/consumer partners. Staffing costs also include allocations for scheduled time off and overtime.

Operating Expenditures:

- General operating expenses (office supplies, phones, etc.) are calculated at 10% of personnel expenses.
- An additional $40,000 is allocated for mileage reimbursement for four full-time staff who will be working primarily in the field.
- Overhead expenses are calculated at 10% of total program expenses.

Non-Recurring Expenditures:
$25,000 is allocated for start-up expenses including training and equipment.

B. Revenues

To be determined.

Innovation Work Plan Narrative

Date: 09/03/10

County: Santa Clara

Work Plan #: INN-08

Work Plan Name: Interactive Video Simulator Training

Purpose of Proposed Innovation Project (check all that apply)

- ☐ INCREASE ACCESS TO UNDERSERVED GROUPS
- ☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- ☐ PROMOTE INTERAGENCY COLLABORATION
- ☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

In "Crazy in America: The Hidden Tragedy of Our Criminalized Mentally Ill" M.B. Pfeiffer states, "In the worst case scenario, lives are lost when over-zealous police officers and untreated mentally ill persons interact in volatile situations." (Pfeiffer 2007) During a recent five-year period 22 officer involved shootings occurred in Santa Clara County; ten of those shootings involved people who were mentally ill.

The professional literature is replete with data that dramatically illustrates the intersection of the mental health and criminal justice sytems, and presents a strong mandate to develop concomitant training solutions. A recent study by the Treatment Advocacy Center and the National Sheriffs Association states that there are almost four times as many people with mental illness in jails and prisons as there are in state and private psychiatric hospitals. Experts estimate that between 9% and 25% of law enforcement officers' time is spent dealing with people who are mentally ill (NAMI, CA Sheriffs Association, Sacramento PD, LA Sheriffs Office). According to the Treatment Advocacy Center, mentally ill people are four times as likely to be shot fatally by police officers than the general public. Similarly, the rate at which mentally ill individuals kill police officers is more than five times greater than that of non-mentally ill individuals.

Despite the frequency with which law enforcement officers are expected to manage mental health-related crises, less than eight hours of the approximately 1000 total hours in the State's Basic Academy Curriculum are related to mental health. (CA POST Learning Domain 37) According to CA Department of Justice statistics, there are 3780 law enforcement officers in Santa Clara County. At maximum capacity, the County's six CIT sessions per year reach less than 200 officers. Inadequate training leads to unnecessary hospitalizations, unecessary incarcerations, reduced access to mental health services, and increased use of force by law enforcement officers.

The purpose of this project is to create and present an effective mental health training delivery system for field law enforcement officers by adapting an existing technology in

a new and innovative manner. Improving the ability of field law enforcement officers to recognize and appropriately respond to mentally ill people in crisis will result in improved service engagement and outcomes as hospitalizations and incarcerations are reduced and referrals to mental health services are increased. The unique collaboration of consumers, family members, ethnic communities, mental health and law enforcement working together to improve law enforcement mental health training represents a truly innovative collaboration.

Interactive Video Simulator Training (IVST) has historically been used to provide law enforcement officers with force option training (i.e., shoot-don't shoot). Santa Clara County law enforcement agencies, like most agencies across the State, currently possess the technical capacity to present IVST; however, due to the absolute lack of videos specifically presenting mental health scenarios, agencies have been forced to limit the application of this technology to force option training. Adapting this technology to mental health training represents an exciting and truly innovative application. Research with several police agencies across the State and with vendors confirmed a current lack of videos specifically presenting mental health scenarios, and generated enthusiastic interest in widespread application.

IVST will provide field law enforcement officers with the practical decision making skills they need to to recognize mentally ill people in crisis, de-escalate crisis situations, increase referrals to service and improve outcomes, in a culturally diverse environment. As opposed to passive lecture discussion methodologies, IVST involves officers in real time problem analysis and decision making. In this training, officers are exposed to a variety of life-sized, videotaped mental health crisis scenarios, and must then make appropriate decisions and responses. The video scenario then adjusts based on the officer's decisions and actions. The project proposes the development of 6 scenarios, each containing at least 4 decision paths.

During the planning process, law enforcement agencies, consumers and family members, especially those from ethnic communities, advocated for more and better training for law enforcement officers. Stakeholders expressed their concerns about officers' abilities to effectively manage mental-health related crisis events especially when those events involved members from ethnic communities who may present linguistic or cultural barriers to communication, or may harbor a fear of law enforcement officers. Law enforcement agencies need an efficient and effective training delivery system that provides officers with the knowledge and practical skills they need to respond to people experiencing a mental health crises, including specialized training that focuses on appropriate responses to ethnic communities. At the same time, ethnic communities need to be able to impart or infuse their specific cultural needs into the training that the officers receive in order to make the training more realistic and effective. Currently, the only models available for this input involve infrequent or crisis-driven community dialogues that include law enforcement administrators rather than field officers.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

This innovation project has two primary goals, both of which will produce positive outcomes. The first goal is to establish a process where consumers and family members, especially those from ethnic communities, can directly impart their perspectives and needs as they collaborate as equal partners in the creation of an innovative training delivery system for law enforcement. The second goal is to create a series of interactive video scenarios and lesson plans that will profoundly impact the way law enforcement officers respond to mental health crisis situations in Santa Clara County and beyond.

The project is a collaborative effort involving consumers, families, ethnic community members, NAMI, the San Jose Police Department, the Santa Clara County Sheriffs Department and the Santa Clara County Mental Health Department. The project will be implemented in two phases. In the first phase, the project team, including the individuals and groups named above, will create video scenarios that teach law enforcement officers how to recognize, approach, and respond to the needs of consumers experiencing mental health crises, including how to overcome ethnic and cultural barriers. The IVST will place officers in decision-making roles as they interact with life sized, video projections of consumers in realistic mental health crisis scenarios. The video scenarios will include input from and include actual consumers and family members, including those from underserved and ethnic communities. Consumers and family members will be involved in all phases, including scripting, acting, video production and presentation of the training. In the second phase, Mental Health Department Law Enforcement Liaisons will work with all County law enforcement agencies to incorporate the new mental health realted scenarios and lectures into the interactive video training already in use for field officers.

Upon successful demonstration of the project, widespread distribution of video scenarios is planned. Videos will be distributed to all California CIT programs and to all interested law enforcement agencies throughout the State and the Nation. The project team also plans to deliver a presentation and a demonstration of the project at the 2011 International CIT Conference in Florida.

This project is in alignment with the following MHSA General Standards:

1. Community Collaboration: The project increases collaboration with consumers, families, ethnic and underserved communities, and law enforcement.

2. Client and Family Driven Mental Health System: The project will include the active participation of consumers and family members in all phases of development, presentation and evaluation.

3. Cultural Competence: The project will include the active participation of representatives from ethnic and underserved populations in all phases of development, presentation and evaluation. Increased referrals by trained law enforcement officers will reduce disparities in service.

4. Wellness Recovery and Resilience: The project will decrease ciminalization of the mentally ill and increase service engagement and recovery.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

This project introduces an existing training delivery system (Interactive Video Simulator Training) that has been successful in a non-mental health context (force option/firearms training) into in a new and innovative application (training law enforcement officers to appropriately respond to mentally ill people in crisis).

One of the fastest growing areas of education is the use of technology which offers alternative ways to learn. Interactive Video Simulator Training will allow officers the opportunity to become active learners as opposed to passive listeners. Recent research has consistently demonstrated a positive correlation between learning gains from video simulations and the degree of instructional activity. Research has also shown that retention rate differs with different forms of teaching. Long term memory increases from 10% with verbal processing methods (e.g. lecture, reading) to 30% with verbal and visual processing methods (e.g. audiovisual, discussion group) and up to 75% with kinetic methodologies (learning by doing).

In the proposed training life sized video representations of mental health crises will be shown, then paused for discussion and decision options. In slowing down the unfolding scenario, officers will have a chance to reflect, discuss and select an action option. Based on the officer's selected option, the scenario advances and provides for continuous discussion and learning. This method of teaching increases long term memory, which is where officers need to retrieve critical information for addressing crisis situations.

Contributions to learning include: (1) demonstration of a process where consumers and family members, especially those from ethnic communities, directly impart their perspectives and needs as they collaborate as equal partners in the creation of an innovative training delivery system for law enforcement; (2) creation of the first life-sized, real time, interactive video simulations and lesson plans designed to train law enforcement officers to respond to mentally ill people in crisis. Successful completion of the project will create the potential for widespread application in other jurisdictions.

Specific learning questions addressed by the project include:

Process Question 1: How does the collaboration between consumers, family members, ethnic/underserved communities, NAMI, Mental Health Department staff and law enforcement impact content and training delivery in the adaptation of Interactive Video Simulator Training for law enforcement mental health training?

Process Question 2: How does the adaptation of Interactive Video Simulator Training impact the training of law enforcement officers to successfully address the needs of mentally ill people in crisis?

Outcome Question 1: How does Interactive Video Simulator Training reduce the use of police force and the number of injuries and/or deaths to both consumers and officers when police officers respond to events involving mentally ill people in crisis?

Outcome Question 2: How does Interactive Video Simulator Training reduce unnecessary hospitalizations and incarcerations?

Outcome Question 3: How does Interactive Video Simulator Training increase law enforcement referrals to mental health services and create positive outcomes for consumers?

Outcome Question 4: How does Interactive Video Simulator Training result in increased communication, collaboration and understanding among all stakeholders, including consumers, family members, ethnic/underserved communities, law enforcement and the mental health system?

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: Nov 2010 - Oct 2013
MM/YY – MM/YY

October 2010 – Approval from OAC

October 2010 – November 2010
- Establish Learning Advisory Committee (LAC) to refine project assessment plan including final success measures, data indicators and reporting infrastructure.
- Finalize project implementation plan, and issue Request For Proposal.
- Develop training plan that is acceptable to law enforcement agencies.

December 2010 - April 2011
- Develop LAC-approved content for video scenarios.
- Develop initial video scenarios and test with LAC and law enforcement agencies.

May 2011 - June 2011
- Produce final videos.
- Begin incorporating videos into law enforcment training programs per the above plan.

December 2011 - Begin conducting semi-annual assessment project with LAC.

July 2013 - Present draft project report with initial feasibility for sustaining, integrating or replicating project services or lessons learned to MHD staff, Mental Health Board and the Stakeholder Leadership Committee.

October 2013 - Present final project report with initial feasibility for sustaining, integrating or replicating project services or lessons learned to MHD staff, Mental Health Board and the Stakeholder Leadership Committee.

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an advisory capacity to the project staff for the life of the project. While the membership of each Learning Advisory Committee will be different, all Learning Advisory Committees will include consumers and/or family members, providers, system partners and MHD staff. When appropriate, existing stakeholder groups, committees or task forces will be utilized.

Facilitated and supported by MHD staff, each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members finalize project success measures, monitoring tools and reporting infrastructure. This will ensure that stakeholders, the MHD and project staff have clearly defined objectives and measurement tools.

Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and outcome data. In this role, stakeholders assist staff implement the project by advising on operational issues such as vetting data indicators, problem solving, reviewing reports and connecting clients to other services. The LAC continually assesses the project's progress toward the stated aim, and makes recommendations on how to modify services or activities if objectives (i.e. success measures) are not being achieved.

Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned. In this role, members help connect the project's contributions to the broader system(s) of care.

Final project reports and recommendations will be provided to system partners, the County's Stakeholder Leadership Committee, the Mental Health Board and the Board of Supervisors.

Process Question 1: How does the collaboration between consumers, family members, ethnic/underserved communities, NAMI, Mental Health Department staff and law enforcement impact content and training delivery in the adaptation of Interactive Video Simulator Training for law enforcement mental health training?

Process Question 1 Measures: Interview or survey of the project team members to measure: (1) the effectiveness of the project methodology in adapting Interactive Video Simulator Training to produce effective, culturally appropriate, mental health law

enforcement training; (2) the impact of the project methodology on communication, understanding and collaboration among all stakeholders.

Process Question 2: How does the adaptation of Interactive Video Simulator Training impact the training of law enforcement officers to successfully address the needs of mentally ill people in crisis?

Process Question 2: Measures: (1) Interview or survey of stakeholders, including consumers, family members, ethnic community representatives and law enforcement to evaluate learning value and impact on law enforcement training. (2) Independent evaluation of completed video scenarios by subject matter experts, including representatives from consumers, ethnic communities, mental health and law enforcement.

Outcome Question 1: How does Interactive Video Simulator Training reduce the use of police force and the number of injuries and/or deaths to both consumers and officers when police officers respond to events involving mentally ill people in crisis?

Outcome Question 1 Measures: Track data regarding police use of force, injuries and deaths resulting from police responses to events involving mentally ill people in crisis, before and after presentation of Interactive Video Simulator Training.

Outcome Question 2: How does Interactive Video Simulator Training reduce unnecessary hospitalizations and incarcerations?

Outcome Question 2 Measures: Track data regarding the number of hospitalizations and incarcerations resulting from law enforcement responses before and after presentations of Interactive Video Simulator Training.

Outcome Question 3: How does Interactive Video Simulator Training increase law enforcement referrals to mental health services and create positive outcomes for consumers?

Outcome Question 3 Measures: Track data regarding levels of engagement in service and outcomes for consumers and family members involved in a law enforcement involved event, before and after the presentation of Interactive Video Simulator Training.

Outcome Question 4: How does Interactive Video Simulator Training result in increased communication, collaboration and understanding among all stakeholders, including consumers, family members, ethnic/underserved communities, law enforcement and the mental health system?

Outcome Question 4 Measures: Interview or survey of project team members, consumers, family members, ethnic community representatives and law enforcement to

measure changes in attitudes regarding how law enforcement responses to mentally ill people in crisis, especially in ethnic/underserved communities.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

- Ethnic communities and ethnic advisory committees
- San Jose PD and Santa Clara County CIT programs
- County Police Chiefs Asssociation
- County Police Training Officers Association;
- Policy changes by law enforcement agencies

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Santa Clara

Work Plan Name

Interactive Video Simulator Training

Annual Number of Clients to Be Served (If Applicable)
NA Total

Population to Be Served (if applicable):

NA

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The National Alliance on Mental Illness estimates that 10% of law enforcement calls for response relate to individuals and families experiencing an acute mental health crisis. Despite the frequency with which law enforcement officers are expected to manage mental health-related crisis events, only six of the approximately 1000 total hours in the State's Basic Academy Curriculum for law enforcement is related to mental health.

The aim of this 32-month project is to develop a model to bring the perspectives of family members and consumers to law enforcement and improve the quality of their response during mental health crisis events through the innovative development of mental health related scenarios for inclusion in widely used interactive video scenario training. The perspectives of mental health consumers and underserved ethnic communities will significantly inform scenario development. The project includes three elements:

1. The development of video scenarios informed by and including consumer/family members, including those from underserved ethnic communities;
2. The incorporation of mental health scenarios into existing widely used interactive video scenario training for law enforcement; and,
3. The collection of data to evaluate whether project approach results in improved law enforcement response and improved outcomes for individuals and their families.

If successful, this project has the potential to significantly impact law enforcement response to mental health-involved crises in the community through training that exposes them to “real life” scenarios depicting crisis events as they are experienced by individuals and family members from different cultures. The project is expected to improve law enforcement response skills, improve community trust in law enforcement, and improve the overall safety of those involved in mental health crises.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Santa Clara Fiscal Year: 2010/11

Work Plan #: INN-08

Work Plan Name: Interactive Video Simulator Training

New Work Plan ☑

Expansion ☐

Months of Operation: 11/10- 6/11
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures				$0
2. Operating Expenditures	24,500			$24,500
3. Non-recurring expenditures	140,000			$140,000
4. Training Consultant Contracts				$0
5. Work Plan Management	50,000			$50,000
6. Total Proposed Work Plan Expenditures	**$214,500**	**$0**	**$0**	**$214,500**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$214,500**	**$0**	**$0**	**$214,500**

Prepared by: Jeanne Moral Date: 9/3/2010

Telephone Number: 408-885-6867

Budget Narrative

Fiscal Year 10-11

Note: All amounts represent annualized amounts for the first year of the project's operation.

Innovation Program: INN-08 – Interactive Video Scenarios Training

A. Expenditures

Personnel Expenditures: None

Operating Expenditures:

- Program supplies and office expenses are calculated at 10% of Work Plan Management expenses.
- Overhead expenses are calculated at 10% of total program expenses.

Work Plan Management:
$50,000 is set aside to cover personnel expenses associated with acquiring and coordinating the work of videographers, coordinating the participation of consumer and family partners and working with police departments to incorporate video scenarios into training curriculum. This will entail high level efforts to secure support and cooperation of law enforcement agencies including police chiefs and other law enforcement administrators.

Non-Recurring Expenditures:
$140,000 is allocated to video production including script and scenario development and stipends for consumer and family partners who will advise and act in the video scenarios.

B. Revenues
To be determined.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Santa Clara Fiscal Year: 2010/11

Work Plan #: NA

Work Plan Name: INN Admin

New Work Plan ☐

Expansion ☐

Months of Operation: 7/10- 6/11
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	415,620			$415,620
2. Operating Expenditures	417,280			$417,280
3. Non-recurring expenditures				$0
4. Training Consultant Contracts				$0
5. Work Plan Management	0			$0
6. Total Proposed Work Plan Expenditures	**$832,900**	**$0**	**$0**	**$832,900**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$832,900**	**$0**	**$0**	**$832,900**

Prepared by: Jeanne Moral Date: 9/3/2010

Telephone Number: 408-885-6867

Budget Narrative

Fiscal Year 10-11

Note: All amounts represent annualized amounts for the first year of the project's operation.

Innovation Program: INN Administration

A. Expenditures

Personnel Expenditures:
$415,620 is allocated for the salaries and benefits of 1.0 FTE Innovation Coordinator and 2.0 FTE Project Coordinators. The Innovations Coordinator is responsible for managing community program planning, coordinating reports and documentation to the OAC and stakeholders and supporting the implementation of each project in accordance with approved plans. The Project Coordinators implement specific INN projects, and will be primarily tasked with supporting the Learning Communities, developing and implementing project plans, overseeing procurement of services and program monitoring. They will work closely with the INN Coordinator and operational managers to sustain, integrate or replicate INN services if warranted.

Operating Expenditures:
- General operating expenses (office supplies, phones, mileage, etc.) are calculated at 10% of personnel expenses.
- In addition, $300,000 is allocated to acquire/support the design and implementation of evaluation methods for INN projects.
- Overhead expenses are calculated at 10% of total program expenses.

B. Revenues
To be determined.

EXHIBIT E

Mental Health Services Act
Innovation Funding Request

County: Santa Clara Date: 9/3/2010

	Innovation Work Plans		FY 10/111 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth,	Transition Age Youth	Adult	Older Adult
1	INN-01	Early Childhood Universal Screening Project	$170,158	$170,158			
2	INN-02	Peer-run TAY Inn	$703,529		$703,529		
3	INN-04	Merging the Old with the New	$252,060				$252,060
4	INN-05	Multi-Cultural Center	$481,791			$481,791	
5	INN-06	Transitional Mental Health Services for	$256,025			$256,025	
6	INN-07	Mental Health / Law Enforcement Post Crisis Intervention	$285,209			$285,209	
7	INN-08	Mental Health / Law Enforcement Post Crisis Intervention	$214,500			$214,500	
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26	Subtotal: Work Plans		$2,363,272	$170,158	$703,529	$1,237,525	$252,060
27	Plus County Administration		$832,900				
28	Plus Optional 10% Operating Reserve		$319,617				
29	Total MHSA Funds Required for Innovation		$3,515,789				

Summary of Comments to MHSA FY11 Annual Update and Innovation Plans
Public Hearing - May 18, 2010

1. Community Member #1

I want to raise the voice of consumers and family members that with those updated funds, the department should arrange for more stipends for consumers and family members because this afternoon I saw two consumers who were very excited and very happy. Thank you.

MHD Comment: *While this comment is not specifically directed to the Annual Update or the Innovation Plan, it is relevant to both. MHD is modifying the ECCAC (Ethnic Community Advisory Committee) family and consumer member program in FY11(CSS and PEI funded) and will include this as part of a major FY11 priority of the MHD which is to restructure and enhance Consumer and Family advocacy and involvement throughout the mental health system. The MHD acknowledges that the area of system-wide family involvement has not developed as planned and will make this a top priority for FY11 now that new division managers are in place and they are committed to this effort. With respect to the Innovation Plan, Projects #2 (Peer Run TAY Inn), #7 (Mental Health / Law Enforcement Post-Crisis Intervention) and #8 (Interactive Video Scenarios Training) include provisions for hiring family/consumers.*

MHD Related Modifications to Plan: *The MHD proposes to work through MHB committees and the full MHB and stakeholders to refine Innovation plans to include specifically defined innovation aims and success measures, to each plan. Specific success measures for those elements which include consumers and family member perspectives will be included.*

1. Community Member #2

With consumers and family throughout the bay area and Santa Clara County we've been paying attention to Innovation and 8 work plans. We've been very excited about innovations and we will wait to see the results. On the other hand, we see how the funds are allocated in these work plans. As part of the mental health staff, I wear two hats. I work for the Consumer Affairs Program and I also work for Family Affairs. We understand that next year there have been some cuts in the budget and we only can wear one hat next year and we won't to be able to provide services and work for too many programs like we did this year.

With appreciation we would like to say "Thanks" to those people who are funding the money into these programs for the consumer to have a chance to work and provide some service back to the community and the recovery and wellness process. On the other hand, the Zephyr area is functioning very well. We had an art gallery show which was successful and we invited all of the consumers and family members contributing all of their art work based on what the think about recovery and wellness. That's part of the

work we do and with our thanks and appreciation to those people on the Mental Health Board spending time and your effort to work and to help us.

Thanks to all of you at the Mental Health Board who are sacrificing your time and effort and part of your heart to be here for us. As a consumer I am really thankful. You understand us and you are fighting hard to represent our voice to the Mental Health Department.

I would like to comment that consumers would like more opportunities to be available to us, like full-time jobs. No discrimination and not only be able to work for 10 hours and no benefits. Also, we would ask that with good feeling that you work on these projects so that we will benefit from them.

MHD Response: *The MHD has not reduced the budget or changed the roles of ECCAC members for FY11. Budgets from past year unspent allocations have been exhausted and for the coming year only FY11 funds will be available for ECCAC CSS program contracts. There will be additional funding available through PEI Plan implementation and Innovation Plans upon state approval.*

In addition, the MHD has reorganized the management and oversight of the stipend contracts so that the MHD provides direct oversight of the program. The inclusion of positions for consumers and family members is included in the CSS Plan. The positions were originally intended to be Community Workers with special consumer and family qualifications. Unfortunately budget reductions resulted in 20+ newly created Community Worker positions being frozen for Community Worker staff that were being laid off from other County departments. The Mental Health Department was compelled to delete these MHSA funded positions (to have these positions filled with staff who did not have consumer and family member experience would have not been in compliance with the objectives of the approved MHSA plan). Therefore, MHD redirected the budget for the positions and established stipends for consumers and family members. Approximately 100 consumers and family members will be on board in the coming year.

In addition, the MHD is in the process of developing a county employee classification for consumer/family member positions. This process has taken well over a year to complete due to vacancies in essential management positions, and because the positions must be approved through the County Employee Services Agency and labor organizations before the new positions are formally added to the County Salary Ordinance.

MHD Related Modifications to Plan: *While no additional modifications are proposed to be made to the MHSA plans as a result of this comment, as acknowledged under the response to the previous comment, the MHD is committed to fully implement Consumer and Family Affairs system-wide in FY11.*

3. Community Member #3

I am member of Grace Baptist Church and we have a group called PACT (People Acting in Community Together.) There are 23 churches in Santa Clara County who are members. I'm also a member of the Correctional Institutions Chaplaincy and I go out Elmwood and conduct a bible study with a senior group. I'm also on the Advisory Board with the police board training and I'm on the stakeholder group [Stakeholder Leadership Committee] with Prop 63.

I participated in a least three of the different Innovation project work groups and I understand your frustration with lack of detail. I also understand your frustration with lack of participation because the first meeting I went to had three people and two of them worked for the county.

I have a burning need to see something done with guys getting out of prison with mental problems and the children. All of these issues are important. Some of them had to be massaged to a point where they weren't recognizable when they were finished because they weren't innovative; they weren't new. They were already put into practice someplace else. So they had to be changed in ways that they didn't look like how they started out.

I know all the people that came to the meetings had their heart in what was going on. Some of these things don't look quite like what I would like to see, but they are a beginning. From what I understand the innovation are pilot projects where you start something and you evaluate it. If it doesn't work, you get rid of it and you do something else. That's what this whole thing is all about and I want something to go forward.

I really appreciate all the criticisms because they are things that I've thought about. But sometimes it's hard to get all the flesh on the bones because sometimes you have 30 people at one meeting and then a different group of people at another meeting. It's difficult to get participation and follow through. So I commend everybody who worked on them.

I would have like to see some other things happening. But this is what we have got. So I want to go forward and do it in a constructive way so that we can have a good outcome or know why we don't have a good outcome and then work on something that is going to get a better outcome.

MHD Response: *Significant efforts were undertaken to obtain input from the public and mental health stakeholders to: a) review and prioritize the innovation suggestions as submitted by system stakeholders; and b) to shape the suggestions selected by a public stakeholder process for development into Innovation Plans that were endorsed by stakeholders and met State Innovation Guidelines. The Mental Health Department posted notices for specific plan input sessions and subsequently facilitated 15 sessions to receive input regarding Innovation project proposals. One session was held for each project with*

additional sessions being held for projects that had significant questions, concerns or disagreements from stakeholders. Innovation public input meetings had an average of 11 attendants per session; however, some meetings had few attendees. The process was definitely challenging as there were many different views and interests that were championed during the meetings. MHD staff was tasked with taking all the input and writing final draft plans which were then posted for public comment. The fact that there were very few public comments submitted is assumed to be because those who had the interest in specific plans had participated in the input sessions.

MHD Related Modifications to Plan: *As stated in response to #1, the MHD acknowledges that there is concern about the details of each of the proposed Innovation plans and proposes to work with the full MHB, through MHB committees (or another process proposed by the MHB), and with the inclusion of stakeholders, over the next three months to address concerns expressed by the MHB in the MHSA Annual Update and Innovation Plan Public Forum. This is proposed as a result of the concerns expressed by the MHB at the Public Hearing. The MHD will submit the Annual Update and the Innovation Plan(s) to the Board of Supervisors for its approval to forward the State following this process. A second 30-day posting and Public Hearing may be held.*

4. Victor Ojakian:

I want to ask a few things more for clarification then anything else and to ask that some of what I am about to ask not be taken wrong either.

I have a question. Because in CSS we talk about a 24 hour drop in program and under the TAY category and then for item "2" in Innovative Project we talk about a Peer Run TAY Inn. What is the substantive difference between these two things?

I like the Innovative Project. It reminds me of an innovative project in Humboldt County where they have a peer run self help operation going on an it seems to have had some success. I heard a number of participants had participated in that when I attended a conference speaking about how helpful it has been for them so I think it's a great project.

In the CSS we talk about the Urgent Care Center and we talk about how emergency mental health needs. We didn't do any revisions for the CSS plans that we are sending to the state. Should we have because it sounds like we are curbing some of the hours there? Does this modification need to be explicitly included in the updated CSS plan?

Staff should explain something about how they have to tailor Innovative projects because they are under some constraints by the State. I know that one of the state employees has given us some direction and that's why they put parameters around projects. To be honest with you at one stage I thought about talking with that staff person because sometimes staff say something and then when you really grill them you get a different answer. But

we should understand that there are some constraints that staff are under in developing projects.

People commented about the dot process. Dots were weighted. For the SLC members, dots were bigger than the dots for other folks. In my experience, I've never found anyone who liked the process. When I was on the City Council we tried different things different ways and regardless we always had people upset. I didn't hear anybody say what the process should have been and again I'm not sure we could suggest another process that wouldn't upset another group of people. But maybe people should mention what other process they should have.

I have some problems with some of the Innovation projects. Some of them I don't have problems with. I think Early Screening, quite honestly, it's an innovation and I'd like to see it happen. I found myself in the Suicide Prevention focusing on the very young and very old. What I have found is that it's the group in the middle that has the highest number of deaths. Everybody is looking the other way.

In our suicide work, we tried to involve the business community. I tried some different ways to put pressure. I know some of the people and other leaders wouldn't do a thing.

To me it's tough to talk about projects which you should include and projects which you should exclude because each has an issue.

I think we are going to have a mobile crisis unit beyond younger people. We've all beat each other up enough about this but somewhere it's going to happen. I have a personal commitment to make it happen. People like Jackie know my feeling about that because I prefer a professional person especially in a first break than somebody else responding. That isn't to say something bad about police officers.

I have a problem with the Merging the Old with the New - it's just too far of a stretch for me. But if people have a different process they thought should be done separate from whether it's being heard or not - it should be on the record. If you have some other Innovative projects that you think we should have - put it on the record.

The only other comment relates to what Tito said. For whatever reason, I thought we did a great job in the suicide prevention public forum. We had this room packed. We had four translators corresponding to the languages that people brought up. It was very effective. We had a group of Vietnamese, non-English speaking, who had their own sub-group. We got a lot of interesting information out of that. I was very pleased with that because they felt like there was an opportunity for them to contribute - so they did.

We need to look at ourselves as a Board how we can help further some of these things that we think are needed. For example, for the Family, Children, and Adolescent sub-committee, I have been thinking about ways to attract more people to participate.

MHD Response:

*Regarding the **TAY Plan questions**, the Community Services and Support (CSS) Plan currently funds 24 hour crisis services for transition age youth with a drop-in center provided during daytime hours and a mobile crisis response during the night-time hours. The services provided through the CSS Plan are designed to address discrete crisis episodes. In contrast, the proposed Innovation Peer-Run Transition Age Youth Inn will provide shelter care for up to two months to youth in crisis, with the goal of helping them stabilize in a safe environment led by peer mentors.*

*Regarding **changes to plans**, operational changes to services under an approved MHSA program (aka work plan) do not constitute a change that needs to be approved by DMH. And it is true that the MHD is committed to establishing a 24-hour mobile crisis service and will be exploring how such a service can be established through use of existing resources.*

*Regarding the **method used for selection of INN projects,** the process did not afford more weight to SLC stakeholders than to other stakeholders. Colors differentiated the selections of SLC members and the members of the general public who participated so that all involved could see how SLC members voted as contrasted with attendees from general public. The intent of this differentiation was to support the principle that has been stressed throughout the MHSA planning process, which is, that SLC members are there to consider the perspective of all stakeholders, as well as to represent their own constituents.*

***MHD Related Modifications to Plan**: No additional modifications are proposed to be made to the MHSA plans as a result of these comments, however, as acknowledged under the responses to the previous comments, the MHD is committed to addressing concerns raised by MHB members in the Public Hearing.*

5. Ronald Henninger

I have some kind of general comments. I make these with some regret. I ask myself "why we are here tonight?" Probably the main reason is that the law has dictated this meeting and that also that this is the way the county is spending $3.3 million dollars.

Unfortunately what happened last year when we had this meeting for PEI plans we produced 15-20 pages of comments and what changes came from these comments were basically very little – at least nothing of substance. The concerns that had been expressed from the meeting were poorly answered if addressed at all. So what has changed in the anticipation I have for tonight's meeting is basically very similar. I doubt that any of the comments make it into the documents. So why did I waste time reading the documents and preparing the comments? To stand up for patients who are receiving sub-standard care or no care because the money is being spent wastefully.

Also I'm afraid that Prop 63 could be taken away from the mental health department. I feel that planning development in the presentation of the county's Innovation Plans could be used as a perfect advertising campaign for anyone wanting to show what a waste of money Prop 63 is.

The Adults with Co-Occurring Mental Health and Autism or Developmental Disabilities project in Exhibit C, page 2 under project implementation the number one bullet states that after funding a needs assessment will be conducted I just question when we fund things and then do a needs assessment. I think a needs assessment needed to be done prior to being funded.

Also there is no clear pathway for a collection of outcomes and data for all or at least most of the projects. It seems that most will be developed after projects have already started. This was a concern at last year's hearing. It seems that little has been done to improve the deficiency. Most projects seem to indicate and state that outcomes will be developed as the project goes on with the project team meeting to evaluate progress. This almost ensures that these projects won't be successful. Some of the projects list "quality of life" as outcome measures that will be used to evaluate the effectiveness of the projects. My question is why the validated quality of life forms already in existence are not being used? We will be evaluating the quality of life by asking questions put together by people who are running the study. There are many condition specific forms for quality of life already in existence.

By having people place dots to choose projects that were brought forward it gives the appearance that people who will benefit are allowed to select their own projects. These choices are based on financial gain not merit.

Why was a selection process not done by a committee reading all the submissions so that projects were chosen on merit not on who happened to have the most friends or employees at the meeting or the best sounding title? Other than the answer that it was voted on, what is the explanation as to why this process was used?

Again, the concern that I have and the reason I am pointing this out is that there is no advertising consultant no matter what they would be paid that could give the anti-proposition 63 group better talking points of how this money is being wasted and should be used by the State in another way.

The points that I want to reiterate here are:

Who funds projects and then sees if there is a need?

Who funds projects without a clear way to evaluate what is being tested is better than what has been done in the past?

Who uses popularity contests to select projects where $3.3 million dollars will be spent instead of a more scientific approach?

Who allows people who will benefit the most to select projects to be done?

I brought up the dot thing. I would like to see a systematic approach to evaluation of all proposals and not just a few. In getting the packet, I thought there were some very good proposals put forth in the 140. I just think there should be a much better systematic approach to evaluating these projects across the board prior to choosing any of them.

You have done a tremendous amount of work. But some of the detail is lacking. Even with universal screening, it doesn't give a plan as to what will take place afterwards. How many children will this help? How many children will get services? Some of these issues need to be addressed before I can say this is a tremendous proposal.

I want to see how this fits in with the overall system of the county.

As a Board member, I am willing to put in time to give you my feedback. But the feedback has to show some effect.

MHD Response:
Regarding the question about needs assessment and the proposal regarding ***Adults with Developmental disabilities, including autism****, in developing this project, Mental Health Department staff confirmed that according to the National Institutes of Mental Health, individuals with autism often suffer from multiple and severe mental and emotional problems and that research is needed to identify effective treatments.*
As part of a preliminary review, MHD staff also learned that the state mental health specialty service guidelines, which apply to county and contract agency operated mental health programs, specifically exclude Autism and Developmental Disabilities as qualifying primary diagnoses for reimbursement. As a result, many outpatient mental health programs do not systematically record the Autism/Developmental Disability condition even if they are serving an individual with a co-occurring qualifying mental health diagnosis. While there is no question that there are a significant number of individuals in Santa Clara County with co-morbid conditions, their prevalence and the percentage of those who are receiving mental health treatment, is not well understood. In addition, given the dramatic increase in the diagnosis of autism, those with a specific interest in the mental health needs of the population of individuals with autism, have proposed this project. The MHD has proposed the project commence with a limited needs assessment in order to inform the prevalence and problems affecting this population.
The primary aim of the project is not the completion of a needs assessment; rather it is to identify and apply a new or synthesized treatment approach in order to provide relief to the population diagnosed with these co-morbid conditions.

Regarding the concern that there is ***no clear pathway for the identification of outcome measures*** *for all projects, MHD acknowledges this concern. Innovation guidelines require that projects have identified outcome measures to study the efficacy of new approaches/models being tested. MHD staff are working with the Learning Partnership*

Decision Support staff with evaluation expertise to develop learning questions and specific data indicators to measure the success of the projects. The outcomes to be measured along with data indicators will be in place prior to initiation of services on all Innovation projects. Mental Health Board members along with stakeholders will have an opportunity to participate in Learning Communities tied to each project, whose members will review data and analysis from the projects and make recommendations to the mental health department on a quarterly basis.

*Regarding **quality of life** as an outcome measure, in all instances in which Innovation projects contain language to improve quality of life for individuals being served as a desired outcome, specific data indicators will be identified.*

*Regarding the **selection of Innovation projects being flawed,** the potential Innovation projects were identified and selected through an open and public process and endorsed by the Stakeholder Leadership Committee. The principle underlying the process was that all suggestions are legitimate and that all who participate or have an interest in the mental health system and have ideas were invited to submit their ideas. With the goal of ensuring maximum inclusion of stakeholders and Stakeholder Leadership Committee members in the selection process for Innovation projects, Mental Health Administration staff called for the public to submit innovative ideas and invited stakeholders to prioritize and vote on ideas. The Mental Health Administration made it very clear that ideas were not "owned" by the person who submitted the suggestion, which is why all names of those submitting ideas were removed for the vetting and voting process. The selection process itself was innovative, and as such, has offered an opportunity to improve upon that process in future planning efforts. As the MHD has indicated to the MHB, we are committed to taking the time to address concerns raised by the MHB during the Public Hearing regarding the proposed Innovation plans and will not submit the plans to the Board of Supervisors until all concerns have been adequately addressed.*

*Regarding **connection of projects with the current system of care,** results from Innovation projects will be used to inform current county system of care services in the mental health system of care and how learning from the projects will be used to inform and/or modify services in the future. The Innovation project plans will include a summary of how projects fit into the existing work and services of the county.*

*Regarding the **Early Childhood Universal Screening project** not providing enough detail about follow-up that will be provided after children are screened, staffing for the project includes a new position for a full-time mental health clinician to follow-up with children identified through screening to link them with appropriate evaluations and services.*

***MHD Related Modifications to Plan:** As indicated above, the Innovation project plans will include a succinct articulation of how projects fit into the existing work and services of the county. Each project will also have an added aim statement and a statement of success measures as well as preliminary outcome measures identified for evaluation of projects. A budget narrative that includes specific staffing required for project implementation will also be added to the work plans. In addition, as indicated, each plan*

will have an advisory Learning Community whose members will review data and analysis from the projects and make recommendations to the mental health department on a quarterly basis. In addition, each plan, once approved by the State Oversight and Accountability Committee will have a detailed implementation plan completed, which will outline specific steps for selecting and funding each specific project provider in accordance with County procurement processes.

6. Cheryl Crose

I have to agree with Ron's statement there and also I agree that individual projects that were selected - for Silicon Valley - this is merely mediocre. This is not something that would put us on the map or is something that would be beneficial for the consumers. These plans don't reflect the creativity that this valley offers and frankly the consumers are owed a lot more that what is being presented today.

MHD Response: *The suggestions for the specific plans were the result of an open process where people were invited to submit ideas for innovative projects. Although the MHD did identify four focus areas, there were no additional criteria beyond the State provided Innovation criteria. This may be one of the issues to consider changing in future Innovation planning.*

The MHD believes that the current plans represent a creative slate of Innovation projects when compared with other counties. The projects are largely designed to increase access and engagement for consumers who have been historically underserved and to try out new approaches to reduce stigma and take into account the cultural attributes and strengths of our consumers.

Related Modifications to Plan: *As indicated other responses above, the MHD is ready to address any concerns or flaws in the current plans, and if need be to set aside proposals that upon further consideration by public stakeholders are not deemed to be of the quality that is desired by a consensus of stakeholders, including the Mental Health Board members. For this reason, the MHD is proposing to delay forwarding the current Innovation plans to the Board of Supervisors until questions and concerns are publicly addressed.*

7. Tito A. Cortez

I worked on Strategy # 7 in the Minority Advisory sub-committee of the Board. I'm hoping that before my term expires that I will experience public hearings in languages other than English.

Staff have to work with criteria attached to dollars from Sacramento and federal dollars in developing projects. We have mandates and guidelines to work with. What I would like to see in the future is that we talk about parameters from the very beginning.

We should be here as a partnership. It begins with all of us.

MHD Response: *The Mental Health Department agrees with these comments and recognizes the value conducting public meetings in additional languages to encourage full participation of members of the public who are not conversant in English. We would like to see the MHB and its committees more involved in the MHSA planning process and playing a greater role in facilitating the public conversations that have been occurring throughout the last five years of MHSA planning.*

MHD Related Modifications to Plan: *As stated, the MHD stands ready to work on improving the specific Innovation Plans and the overall MHSA planning process in such a way that MHB members feel a more direct role in the process. One way that might occur is to have the Mental Health Board Chair, or an identified MHB member, co-chair the MHSA Stakeholder Leadership Committee in the coming year.*

8. Jacqueline S. Gutierrez

I helped with Prop 63 and I spent hours and hours collecting signatures and I never dreamed that the money going to Prop 63 is going to salaries, that is going to consultants, that is going to contract agencies.

I am very disillusioned that we are supposed to be advocates for consumers and families. I don't see that the Mental Health Board has any clout with the Mental Health Department. There is no communication.

The plans that I personally have a lot do with is the Merging the Old with the New. It was a waste of time. It was self-motivated by a certain few and what we wanted was never discussed. It was changed all the time.

I have to say that we have to do something for the elderly. Very little is being done for them. They can still be isolated.

And as for the work plan for the Law Enforcement Post Crisis, I think this is ridiculous.

You are decreasing the 24 hour Urgent Care, which to me I can see is the only MHSA funding that was good quality and now you are compromising the quality and safety of care to consumers and their families. The $1.3 million that are counting on us to help them we are not going to help them because of money because of budget and I know there is more money.

It's really sad I will kill myself to pay for COBRA for my son. He will not be in the County because I don't feel the county has anything to offer and I have felt this for the one year being on this Board. This is so wrong that nobody has compassion other than the Board. Nobody has the empathy that we as parents who have someone with a mentally ill son or daughter, husband or wife or grandma or grandpa. They don't know what they are feeling either but there has to be an advocate for the mentally ill. I feel that the Board could do it if our hands weren't tied.

I disagree with law enforcement being first responders. The police departments, most of them, don't have a good reputation. I've seen it first hand. They shoot and ask later. It isn't right. This isn't going to pass.

And the other thing about the video. What the heck is that going to do? That's not going to do anything. Put money into that?

I do agree with the Peer-Run TAY Inn. I think that will be okay and Early Childhood.

And I'm glad that finally Autism is getting with mental illness. They still need to get Autism and dementia with mental illness and the multi-cultural.

Other than those, I'm just really disillusioned.

MHD Response: *The MHSA has made a tremendous positive impact on the current system and it is very concerning that the value of the programs that have been funded is not visible to the important body of the MHB. In two years, the capacity of the system has grown by 4,000, meaning that 4,000 additional people with serious mental illness are being served through an array of MHSA-funded services, for example: 1) Full Service Partnerships provide a broad range of treatment and support to individuals of all age groups who have demonstrated a need for intensive services; 2) new services for uninsured individuals ensure that many of the most vulnerable County residents do not go without car; 3) the Treatment Court, Family Wellness Court and Evans Lane offer recovery-oriented, consumer- and family-driven services to those coming out of the criminal justice system; 4) thousands of very young children who are being connected with needed services through KidConnections; and,5) Mental Health Urgent Care is helping to reduce utilization of emergency psychiatric services. Despite drastic budget cuts, which eliminated $78 million from the MHD over the past 10 years, the system has not turned services away to those that have been served in the past.*

Regarding the ***Merging the Old with the New project and the public input process*** *for plan development, this project was a great challenge because there was not consensus among people who came to input sessions; and the plan drifted significantly from the original suggestion that was voted upon by members. On two separate occasions, stakeholders were given the opportunity to start over on an INN project targeting Older Adults. In both instances, stakeholders voted to continue refining the existing project.*

The project is designed to test an approach of intervention that is focused on the elder and a significant person in their lives. The proposed project aligns with Mental Health Services Act general standards that are required for Innovation projects in that it encourages community collaboration by expanding linkages for referrals of older adults to the program to agencies and groups that are not mental health-related and reduces stigma associated with seeking mental health services by not requiring that older adults who are served fall into a specific diagnostic criteria. The project is designed to test whether utilizing a traditional strength of older adults as the holders of cultural knowledge and values, rather than a clinical treatment approach or diagnostic approach, is effective in reducing isolation and its negative impacts.

Regarding the displeasure with the Mental Health/Law Enforcement Post-Crisis Intervention plan, *this project offers the mental health community of stakeholders an opportunity to learn about how we can better serve clients in crisis providing follow up services following police response events, by asking consumers and their family members directly about what they need and then directing them to services. The desired outcome is to avoid repeat police responses after the police have responded to a call initially; and to insure that follow up and linkage are improved.*

Regarding Mental Health Urgent Care*, and why hours or operation are being reduced from 24 hours per day at the facility, an analysis was conducted to determine when the clinic is most heavily visited and to direct resources accordingly. The night shift at Urgent Care is being cut back because of the cost of maintaining the staffing during those hours when only 1-2 clients are receiving service. The need for emergency, crisis and urgent care response will continue to be evaluated in the coming year and changes and redirection of resources will be made to accommodate needs in a way that maximizes the resources of the system.*

Regarding police as first responders to consumers with mental health crises *the law is clear that mental health professionals are not first responders in the event of public safety emergencies. Unfortunately too many mental health crises rise to the level of a 911 call. Once that occurs, mental health may be utilized by police to provide crisis intervention, consultation and linkage to services. Our objective should be to continue working with the public and police to encourage the use of mental health professionals as crises are developing, which is where drop- in services, urgent care, and mobile crisis services can be very effective. Both mental health and law enforcement stakeholders agree that exclusive utilization of law enforcement officers to respond to mental health consumers in crisis is inadequate.*

Unfortunately, the crisis mobile response team model does not meet the requirements for Innovation projects because it is not a new approach. Mobile crisis response teams are underway in many cities and counties across the country. State guidelines for funding of Innovation projects stipulate that approaches that have been successful in one community will not be funded.

To address the concern that an exclusive law enforcement response to consumers in mental health crisis is inadequate, the proposed Mental Health Law Enforcement Post-Crisis intervention project aims to reduce follow-up police responses to consumers and family members by more effective engagement into services.

Regarding the Interactive Video Scenario Training project, *through technological innovation, the Interactive Video Scenario Training project has the potential to dramatically increase the number of law enforcement officers who are exposed to scenarios related to mental health consumers in crisis and consider alternative ways of responding to them. This model is very effective in teaching individuals who work in high stress situations that require split-second decisions that could be life-saving.*

MHD Related Modifications to Plan: The MHD is committed to have concerns raised by MHB members addressed through further meetings facilitated by MHB. The MHD looks forward to the process the MHB recommends to achieve this.

9. Charles Pontious

I thank you for coming. I thank you for your advocacy. It is the involvement of the community that really makes the system work. All of us are doing our part by being members of the Mental Health Board and I know that all of you are doing your part by various volunteer agencies. Whatever disagreements we have, I would like to thank you on a professional level.

I was not part of the MHSA cause, so it's difficult for me to be overly critical. I would like to say quite honestly after reading this, had I seen what the money was spent for, I would not have voted for it. It’s interesting for the Mental Health Board going to meetings where we see basic services being cut on a daily level and then we see basically a $43 million dollar slush fund which is obscured by forms. **(1)** I know a little bit about technology and I would have liked to have delved deeper into that. I can't believe that so much money is being spent on Technology projects. I wouldn't be able to spend that much money at work without a lot more explanation of what the money is for and detailed budgetary cost comparisons. That's probably beyond the scope of the Mental Health Board so that's why I was hesitant to make the comparisons. But I would like to say that regarding the Technology projects, I don’t feel this is enough information. For example, $13,000,000 for one project and $3,000,000 for a data warehouse project. I have done that before and I just can’t imagine what those dollars are going for.

The Valley Medical Center served the underserved. I'm here to tell you that those with private insurance are just as underserved as those with no insurance. In fact, I believe that those with private insurance are mistakenly considered to be privileged. I am here to tell you that when we hear health care debates that those with private insurance have found that they have no voice in this nameless bureaucracy that has no care for their welfare. And you guys are the people that do care. I truly believe that no matter how much we

criticize you that you have to understand that your service in the community is about all there is.

The difficulty in this for one is that while I really value serving the underserved, the programs are all couched in that and then they are aimed at particular ethnic groups. The programs are not really serving the underserved; they are serving the community. That is probably appropriate considering your charter but I just wanted to be a voice for all those with private insurance that find themselves at Valley Medical Center because they have no place else to go. These are programs for people on public assistance and I believe that puts a stress on you. I believe that unless something gets done through health care reform to somehow bridge the gap to compensate you for the people you serve who should be under the private health insurance net, you are never going to have enough money.

I would also guarantee you that were the voters to see what this money is being spent for; you would not have the money you have. I honestly believe that.

As well meaning as some of these projects are and as well meaning as they were in 2004, we are in a different climate now. We are in a very severe time where we are cutting back 24 hour urgent care and yet producing videos for people. It just doesn't seem right.

There isn't anything wrong with preserving money for innovation programs just as you need to preserve some bandwidth for high speed packets. Innovation will never happen unless you set aside money for it.
In summation, I would like to say that if you want real input on where the money is spent, I can give you a lot more input on what it would take to provide that. A lot of work went into preparing these reports; but it's nothing I would make decisions on. It looks like application material for the state, not for a review board.

In general I think some of these projects are really guided in the right place with the budget scenarios we need to focus on obvious ones that need to be cut.

The thing I like most about the other comments is to get outcome-based measurement.

I think the extent to which we are running this like a business, we would all be the better off. At any time money could be taken from one part of the business and given to another.

MHD Response*: Regarding the CSS, WET and PEI Annual Update, the Annual Update was prepared to meet State requirements for identifying changes to existing programs (aka Work Plans), proposing new programs or eliminating programs. Details for each existing program can be found in the original program submission. Initial CSS, PEI, WET and TN plans are posted on the MHD website. Each plan was developed through an extensive community planning process and publicly vetted with stakeholders. In addition, MHB members may request budget details for each program and service funded by the MHSA. The MHD is willing and has made staff available to answer questions in detail.*

Regarding the TN Projects, *the approved TN projects are intended to support the entire public mental health system (County and contractors). Sheila Yuter (MHD) and Sue Clements (HSS Information Services) are the project leads and are available to answer questions. There was an extensive planning process and public input meetings held to complete the plan. An executive summary of the plan can be found on the county website.*

Regarding serving individuals with private insurance, t*he MHD acknowledges that some individuals with private insurance remain "underserved" or inappropriately served, and that an effective community response to mental health needs is challenging.*

Regarding the funding of Innovation projects when other services are being cut due to the challenging budget climate, *the Mental Health Services Act stipulates that approximately 5% of each county's ongoing planning estimates are to be set aside for projects that meet the State's INN guidelines. This allocation cannot be changed without changes to State regulations. Counties are given the option to apply or not apply; however if a county does not apply for the funds this results in a net funding loss of 5% for total MHSA funds available to the county. In addition, all INN funds will revert to the State if not expended within three years of issuance.*

Regarding the format for information provided by the Mental Health Department to the Board for review *the MHD is open to input about alternative formats that board members would find helpful.*

Regarding the comment that the projects should have outcome-based measurement, *the MHD is committed to working with the Board and community stakeholders for inclusion of outcome measures with specific data indicators in all Innovation projects to be in place prior to initiation of project services.*

MHD Related Modifications to Plan:

As indicated above, the Innovation project plans will include a succinct articulation of how projects fit into the existing work and services of the county. Each project will also have an added aim statement and a statement of success measures as well as outcome measures identified for evaluation of projects.

10. Wesley K. Mukoyama

I've just returned from a 36 day road trip. I've come to see that Schwarzenegger is trying to cut out mental health all together. I read in the paper that Sacramento County is going to close its outpatient services so everyone is going to go to the emergency room. I believe that a certain part of mental health care should be run like a business - yes it should be accountable. However, business if run on review bringing in money and you

don't do that always with the critically mentally ill. You have to have a public policy to help those people whether it brings in money or not.

We should have outcomes. We should be accountable. But you can't have money for outcomes if you don't have inputs**.**

I must say that I am disappointed with the Innovation program. I agree with Jackie. However we have to work with what we get.

I think the emergence of the older adult or people over 65 is greater than you think. It's about time mental health started thinking about older adults. By 2020, if we don't do anything about depression in older adults, it will be the number one killer of older adults**.**

This Innovation program, Merging the Old with the New doesn't really touch that. We have to focus on a growing population that will flood our emergency rooms with illnesses compounded by depression. We have to teach families how to distinguish between depression and dementia. If we don't do that from the mental health department, we're in trouble**.**

Yes, we can run like a business but we have to think about the people that Schwarzenegger is writing off. We have a public obligation to take care of these people who can't help themselves. Mental Health is just one of the departments that has to help that.

I know some people have called us Santa Clause County. But that hasn't been the case ever since I have served on the Board. How can you provide tremendous outcomes when you are constantly facing cuts?

I think there needs to be better communication between staff and the Board. I am also frustrated at times that there is always a timeline that is coming from outside the county.

However, I think the process with dots - there should be some consultants saying these are innovative projects, not just last minute ideas from people. Also, you can't always communicate in public. Sometimes you need to talk to people directly and through e-mail.

MHD Response: Regarding the statement that projects should have outcome measures, *each project will also have an added aim statement and a statement of success measures as well as outcome measures identified for evaluation of projects.*

Regarding the inclusion of older adults in mental health planning*, the MHD agrees that increased attention on this growing population is needed.*

Regarding the concern that the Merging the Old with the New project for older adults does not address issues of significant concern for older adults, *the MHD has recently become aware of a Stanford research project in which guided autobiography writing is*

being studied as potential therapy for prevention of dementia and age-related cognitive decline. The MHD is exploring the possibility of enlisting aging research experts in the program development and evaluation of the Merging the Old with the New, which includes guided storytelling and other cultural practices.

Regarding the need for communication between MHD and Mental Health Board members, *the MHD wholeheartedly agrees and looks forward to the opportunity to beginning a process of discussion and collaboration to improve Innovation projects.*

Regarding the comment that consultants should inform the process of determining whether proposed projects are Innovative, *the MHD has engaged in ongoing consultation with an Office of Accountability Commission consultant, who is an experienced psychologist hired specifically to advise OAC as well as counties. Upon request, it is possible to invite the consultant to attend a MHB meeting in order to respond to specific questions the MHB members may have.*

MHD Related Modifications to Plan: *The MHD is committed to have concerns raised by MHB members addressed through further meetings facilitated by the MHB. The MHD looks forward to the process the MHB recommends to achieve this.*

*Also in response to concerns expressed about accountability of projects**,** the Innovation plans will include a succinct articulation of how projects fit into the existing work and services of the county. Each project will also have an added aim statement and a statement of success measures as well as outcome measures identified for evaluation of projects.*

11. Hilbert Morales

I think the health care system is the victim of some success. I would remind the public that in the 1900's by the time you were 49 you were dead. In 2010, I'm 81; I should have been dead 30 years ago. A lot of this has to do with the fact that with increased dollars and applied technology the ability of health care professionals, including mental health professionals, has enabled individuals to live a longer life in wellness and productivity.

My one suggestion is that a line item be added to each program with the purpose of identifying those resources which are to be used to inform our county's constituents that these programs exist and what may be done to access these programs and their professionals. This information needs to be disseminated through mainstream media as well as media which targets and serves out ethnic communities.

MHD Response: *The MHD acknowledges the need for communication about the system and the availability of resources. Many of the MHSA plans include strategies to engage*

the public in services, particularly among underserved populations. Nonetheless, there continues to be a shortage of strategies to communicate and advertise services.

MHD Related Modifications to Plan: *The MHD recommends that each INN Plan incorporate a feasible communication strategy that identifies how potential service recipients will be informed and engaged in projects.*

12. Julianna Brooks

I will have been on the Mental Health Board for a year in June. Part of the sadness for me is the empty chairs in this room. The fact that there is such a huge need in this county - what are we doing to get the word out?

The other thing that makes me sad and feel extremely powerless is that there are committed public servants on this Board and I feel like we have absolutely no effective change to what's happening to the services of this county. I have a full-time job and a child that I love. I'm not doing this for any other reason other than that I believe it's my responsibility as a community to give back and give service. That's why I chose social work as a profession. That's what it saddens me that there doesn't seem to be any willingness on the part of the public employees in this room to actually accept and be willing to take direction in a working partnership from people who are here not just by law but one are here because they feel passionate and have something to give. They have expertise and experience. To me there is nothing sadder.

I want to say about the plan, our emphasis should be on serving this community wherever this community need is. When we are talking about funding innovative programs some of which are written like grass roots projects for $3.3 million dollars and we are talking about cutting Urgent Care services to the community and we don't have people to don't have people to speak in all the languages of all the people that are in need of services, this is a shame. Shame on all of us for this plan.

I appreciate the time every public employee puts in to their work. I'm asking that we really look at what we are doing here and look at some real partnership and move this forward from a place of cutting out comments which is no one's right in a public forum - to listen to what the community needs. That's an innovative thought right there. - let that drive us.

Let's not spend hundreds of thousands of dollars on a research project comparing consumer driven versus what we are doing now. Why don't we just take a little piece of that and compare it and then decide what is effective and what is worth funding and then fund it? This is practical use of public dollars.

The good news is that we are in a good place this year. We are not looking at cuts as a department. That's great. The bad news is that we are producing a plan like this.

MHD Response: *The MHD acknowledges that MHB members feel disconnected from the MHSA plans under consideration. In addition, it is acknowledged that volunteer MHB members do not have the time to attend numerous meetings and/or to spend excessive hours reading documents. The challenge of communicating efficiently and sufficiently has been daunting given the size and complexity of the system; as well as the new planning efforts that have been underway for the past several years. The MHD will continue to discuss how knowledge and information exchange can best be facilitated between the Department and the MHB.*

MHD Related Modifications to Plan: *The MHD proposes to delay the submission of Innovation plans so that each of the eight projects can be further discussed with Mental Health Board members and other stakeholders and potentially revised or even removed from submission. The initial process used for development of this particular MHSA component was intended for to invite all potential stakeholders to provide suggestions for Innovative projects. The MHD disagrees that this process will favor those who would benefit financially, as funds for most projects will be administered through county procurement policies. The project that received the most votes was the Multi-Cultural Center, which was championed by consumers and family members and strongly endorsed by stakeholders*

13. Carol Irwin

So we have come full circle now and I make the final comments. Where is the public? Where is the public? Why are they not here? Do you know why they are not here? Because they know that if they come it doesn't matter that they've come because no one is going to change the plan.

I've been doing this for a number of years now and it makes me sick because I am devoted and dedicated and I see a vision for this county and what I am looking at here is an abomination. This is an abomination. If you were my students in school I would give you an F. I'm sorry we deserve more than this.

We need to hire our consumers full-time.

We need to include families.

We need to have plans that have detail; that have a process that's clear and that results in consumers getting well.

It's about people getting well. And the buzz word wellness. I don’t want to hear that word because your idea of wellness is a buzz word. There's absolutely nothing behind that. When you have smoking in your clinics, people that are 200 pounds overweight, you have meals that are highly saturated in fat. Please do not tell me that these programs are wellness.

We wanted an Urgent Care Crisis mobile unit to help families in the middle of the night when their kids are ready to kill themselves. And what did we get? A video. Please give me a break.

When will you wake up? Where is the public? When will you contact the press? How do they know what you are doing with these plans?

Then you are going to go to the Board of Supervisors and say the Mental Health Board approved these plans and now you are going to approve them and then you go to the State and then you get your money and then we get this.

I am sorry for being emotional but I have seen what these illnesses do and it isn't pretty. So I'll try to contain myself and move forward with the rest of the meeting. And I apologize. It would be nice to know that you would listen to the Mental Health Board and work with us instead of working behind us to get rid of us.

MHD Response: *The MHD acknowledges the dissatisfaction and frustration that the MHB members have expressed about Innovation plans and previous plans. Regarding low public turnout at the hearing, the MHD acknowledges the need for stakeholders and MHB members to dialog and share perspectives directly with each other.*
The Mental Health Department is committed to administering Innovation projects in order to learn how to better serve the people we care for in the public mental health system of care.

MHD Related Modifications to Plan: *The MHD proposes to delay the submission of Innovation plans so that each of the eight projects can be further discussed with Mental Health Board members and other stakeholders and potentially revised or even removed from submission. The MHD is committed to have concerns raised by MHB members addressed through further meetings, facilitated by the MHB, with stakeholders who have been involved in Innovation project planning and other interested members of the public. The MHD looks forward to the process the MHB recommends to achieve this and stands ready to accommodate MHB needs for this process.*

MHSA STAKEHOLDER LEADERSHIP COMMITTEE MEETING
SUMMARY FOR SLC MEETING ON July 19, 2010

Agenda Item	Summary of Discussion and Actions
Announcements & MHSA Planning Updates	Ky Le provided an overview of comments received during the public posting period and May 18 MHB hearing for the FY 10-11 Annual Update covering the CSS, PEI, WET and Initial Innovation plans. In addition, he provided a summary of substantive changes the MHD made to the plans in response to those comments.
PEI Statewide Projects Supplemental Assignment	Ky Le provided an overview of the proposal to "re-assign" the County's allocation for PEI Statewide Projects ($7.7M) from the California Department of Mental Health (DMH) to the California Mental Health Services Authority (CalMHSA) – a joint powers authority – for administration of the projects. If this action is not taken, then DMH will administer the programs. Reassigning the funds to and joining CalMHSA will allow the County to more directly influence the development of the programs. During the public posting period no comments were received and the MHD will proceed with the original unchanged proposal and will request that the Board of Supervisors approve the assignment at the same time that it requests the Board to consider allowing the County to join CalMHSA. The MHD clarified that only counties can join CalMHSA. Local stakeholder could provide input by 1) attending meetings of CalMHSA, 2) submitting comments directly to CalMHSA or 3) communicating through the SLC and the MHD.
FY10-11 Annual Update	The primary purpose of the Annual Update is to allow the County to access additional MHSA funds for CSS, PEI and WET programs, but not TN, in FY11. Subsequent to the posting period for the Annual Update, the MHD updated program budgets to reflect the most current information. While no new programs were proposed, several administrative changes and funding increases required the MHD to complete exhibit Fs for CSS program C-01 and HO-01. The MHD changed the CSS HO-01 program by increasing "one-time" funding by $50K to support Destination Home and moved services not targeting homeless clients to other CSS programs. The CSS C-01 program was changed to by the redirection of $250K (out of $450K set aside for services to foster youth) to ensure that CBO's could continue to provide services to uninsured youth. In addition, increased funding for C-01 exceeded the 15% limit because additional funding for Kidscope/KidConnections is needed for FY11. The MHD staff emphasized that the key task of the SLC will be to help develop a long-term CSS plan given the projected reductions in CSS funds. CSS programs will be the most impacted of all the MHSA components affected due to expected declines in state tax revenue and because the current funding level includes significant allocations to "one-time" programs. In response to a question by a stakeholder, the MHD clarified that that prudent reserve and unexpended funds were accrued.

MHSA STAKEHOLDER LEADERSHIP COMMITTEE MEETING
SUMMARY FOR SLC MEETING ON July 19, 2010

Innovation Plan	An overview was provided of the substantive changes uniformly made to all Innovation plans as a result of prior comments from the: OAC, MHB May 18 public hearing, MHD staff reviews, and additional stakeholder input through public input meetings. The MHD shared plans for project implementation including staffing, evaluation, and the role of the Learning Advisory Committees. Prior to the July 19 meeting, the MHD worked with small groups of stakeholders to develop a presentation about each project and select stakeholders to present to the SLC and MHB. During the meeting, 2-4 stakeholders for each project presented about the significant substantive additions made to the plans in response to comments.

INN Comments/Responses at July 19 SLC meeting

INN Projects - General Questions

Who decided 2 yrs or 3 yrs? *Stakeholders involved in project planning gave input to the length of time planned for each project. Project duration is defined as sufficient to evaluate and determine the efficacy of a model being tested.*

When establishing a clinic location shouldn't it be necessary to be along a bus route? *The accessibility of public transportation is an important factor to be considered when in determining project location.*

Overhead costs-explain difference between what is on the INN grant proposal and what is being presented? *The INN admin budget is for 2.0 FTE to operationalize the projects in a timely manner; existing 1.0 FTE- coordinator and a significant amount for evaluation of projects.*

INN-01 Early Childhood Universal Screening

Could there be community screening to identify children not seen in the doctors' offices? *First 5 screens kids in courts, Child Welfare Dept, and Juvenile Justice system, Head Start, Early HS, planning to move to S County Health clinics and SJ health clinics, and power pre-school.*

Any privacy issues with this process? *HIPAA and other confidentiality requirements will be presented to parent before they begin screening.*

How will literacy levels, language needs, human factors related to use of technology be taken into account? *Leveraged resources from partner agencies and some degree of staffing will be directed to assisting parents/caregivers to complete screens.*

INN-02 Peer Run TAY Inn

Further clarify the budget increase. *Initially the amount of funding allocated was sufficient to augment an existing program. The current amount allocated reflects sufficient funding to create a new program without leveraged resources*

Are transportation issues being considered? *Provide bus passes, center would be located close to public transport. Youth would spread the*

word to other youth about this service.
Need to address the upheaval of recent immigrants. *Immigrant transition age youth (including those who are undocumented) are particularly high-risk and require culturally and linguistically competent responses.*
Peer volunteers – who would supervise the peer volunteers? *The peers would be paid staff, supervised by other paid staff, some of whom would not be peer partners.*
If we spend less can funds be rolled into other INN projects? *Yes.*
Is there enough staffing? Supervisors, shift supervisors and program managers- all would be paid, including the youth.
Budget narrative is a prorated budget. Summary table of budget is a full annual budget. There is sufficient staffing to procure a program with this model. With this staffing model, there are 12.2 FTE instead of the 6.0 originally planned for.
How many youth will be served? *8-10 to stay overnight. Plus drop in day time services.*

<u>INN-03 MH Disorders in Adults with Autism and Developmental Delays</u>
Will the program penetrate into ethnic communities who speak languages other than English? *While the purpose of the project is not to test whether the new approach increases access to services for underserved communities, the provider will need to provide services in a culturally competent manner for those in the program.*

<u>INN-04 Older Adults</u>
If an older adult is isolated due to prolonged illness, would they still be able to benefit from the project? *For older adults referred to the project with health, mental health or other service needs, the project has significant provision for case management, referrals, and service linkage beyond the 12 weeks in which the main program offering is delivered.*
Are there plans to outreach to non-English speaking older adults? *Yes. The project anticipates the hiring of Spanish, Vietnamese, and English-speaking staff.*
Are there 4 full time staff? *Yes*
Is isolated older adult living alone? *Older adults served by the project may be physically or emotionally isolated.*
Are you starting a new story telling program or certified in current program that exists? *The program model will modify existing best practices.*
How will you engage the family? *Family members will be actively involved in process of reminiscing.*
How was 2 years funding decided? *With 2 years, we would have 5 cycles and would have enough data to determine if the project is beneficial and effective*

Many older adults with families who are isolated experience abuse and other issues. True. The project needs to be a collaborative effort, working with EPS, law enforcement, across agencies.

INN-05 Multi-Cultural Center

There are divided ethnic communities? How will you address this? *Everyone will have to work together on a daily basis. Staff will work with ethnic groups to resolve conflicts and identify inter-ethnic strategies to address problems.*

When looking at penetration of mental health services and languages, several languages are not represented at all. Also languages not represented in ECCAC. (Indian, Farsi) *It may be necessary to direct some resources from the project to reach out to ethnic communities not represented in ECCAC groups. All cultural groups are welcomed.*

INN-06 Transitional Services to Newly Released Inmates

Will there be a volunteer or staff who accompanies newly released inmate? *Project staff will work with DOC to facilitate in-reach access for discharge planning. The faith-based groups will affirm housing, transportation, medication. A Project Coordinator will arrange for training and connectivity to existing services to ensure ongoing support.*

INN-07 Mental Health Law Enforcement Post Crisis Response

Are the police debriefed in this proposal? *Yes. Law enforcement representatives will participate on the learning advisory committee for the project, which will convene bi-monthly. However, the project staff and the Learning Advisory Committee will still need to determine the extent to which individual officers involved in the incidents will participate in de-briefings.*

INN-08 Interactive Video Scenario Training

Who will participate? *Mental health department law enforcement liaisons, consumer and family representatives, and other stakeholders will develop video scenarios.*

Will there be a facilitator with these video presentations? *The video scenarios will be incorporated into CIT training. The project will also make the interactive video scenarios available for inclusion in training offered to all law enforcement personnel and in doing so reach officers that do not receive CIT training. At CIT trainings, there will be a facilitator present through the use of existing leveraged resources. However, eventually if the scenarios are incorporated into basic law enforcement training curriculum outside of CIT, the project does not budget for facilitators.*

Debriefing of those officers who do the interventions is needed. *Although debriefing of law enforcement officers is outside of the scope of*

the project, law enforcement personnel will participate in a Learning Advisory Committee for the project. Within the LAC, there are opportunities for dialogue between representatives of various stakeholder groups.

Accountability. What will we hold the police force as a whole to? *The project is intended to achieve incremental progress with the problem of inadequate mental health training for law enforcement and associated negative outcomes that arise for consumers/family members. The project attempts to reach greater numbers of law enforcement personnel through the inclusion of video scenarios that bring the perspectives of mental health consumers and ethnic communities into existing law enforcement trainings.*

Answers to MHB Questions

The following are answers to questions submitted by the members of the Mental Health Board (MHB). The MHD's responses to these questions were distributed to participants (and posted for the public) of the July 19, 2010 Stakeholder Leadership Committee (SLC) meeting. The questions and responses were also discussed at each meeting.

Questions 1 through 4 relate to the INN Plan in general. Questions 5 through 10 applies to each individual INN project. Thus, while an introductory answer is given in this document, project-specific answers can be found in each project's "Aim Statement," Work Plan Narrative (Exhibit C) or Work Plan Description (Exhibit D). In addition, these questions will be further addressed during the stakeholder's presentations. Question 11 is in regards to the Community Services and Supports (CSS) Plan. The question is answered here and will be discussed during the July 19, 2010 SLC meeting.

1. Once the county receives these MHSA Innovation Project dollars from the State, does the MHD have jurisdiction to change the projects, or redirect the funding? Or is the funding locked into these project designs? If it can be changed how will all concerned be informed?
When INN projects are approved, the County is authorized to incur expenses against each project, and receives the total funding requested for the approved projects for a specific fiscal year. As with the CSS and Prevention and Early Intervention (PEI) components, the MHD is authorized to move funds between INN projects and to adjust services so long as the target population and the overarching goals of the project(s) are not changed and so long as the project continues to meet the State's definition of "innovation." For example, during the procurement process, one project may cost less than initially budgeted, while another project may cost more. In this instance, the MHD can alter funding allocations for each project. The MHD cannot redirect unexpended funds into a new project altogether; however, it can choose to terminate a project after consultation with stakeholders.

The nature of the INN projects and the constant evaluation and assessment necessitate some flexibility in program design. It is anticipated

that the Learning Advisory Committees will be engaged in improving/adjusting the program design throughout the life of the projects.

The MHD anticipates that reporting on the progress of each INN project quarterly to the SLC and MHB. The need for significant changes to funding could be discussed in those forums.

2. What happens to the MHSA Innovation monies if a project is not supported by the MHB? *If a project is not supported by MHB, then the MHD must decide whether or not to submit the project to the Board of Supervisors. If a County-submitted project is not approved by the State, then the funding that was allocated to that project remains at the State. All INN funds are subject to reversion if not expended within three years. Based on when the funds were made available, the published INN planning estimates (annual funding allocations) and when the INN guidelines were issued, the County must expend approximately $6.5 million by June 30, 2012. For example, if only $6.0 million are expended by June 30, 2012, then $500,000 will revert to the State for allocation to all Counties using existing distribution formulas.*

3. Does the funding of these projects include funds for location, business expenses, needed insurances, transportation, forms, advertising etc...? *The expenses for each project vary, and are based on the project's services or activities. As part of a new requirement from the OAC, the MHD has inserted a budget narrative for each of the projects including one for administration. The expense category "Operating Expenses" is very broad, and can include all of the expenses listed in the Mental Health Board's question. In addition to very specific project needs, a project's operating expenses include office supplies, office equipment, shared facility expenses, postage, etc.*

4. What structure is in place to manage, oversee and steward the projects, by the MHD? *In addition to personnel directly associated with each project (as described in the budget narratives) and existing MHD managers, the INN projects will be supported by the following.*

- *The MHD's Program Planning and Development Team, including the MHSA Project Manager and the Innovation Coordinator, is responsible for working with stakeholders and other staff to fully develop implementation plans and program designs once the projects are approved by the Board of Supervisors and the State. For both contracted and County-operated projects, the team plays a lead role in ensuring that all program issues – operational, financial, legal, clinical, evaluation, etc. – are identified and addressed. The Innovation Coordinator has primary responsibility for communicating lessons learned and reports to the State and to stakeholders, for supporting the development of the Learning Advisory Committees, for monitoring fidelity to the approved project, and for assisting the MHD incorporate lessons learned into the existing system of care. The team will also coordinate the development of new INN projects based on funding availability, system needs and stakeholder input.*

- *For each INN project the Mental Health Department (MHD) will convene a "Learning Advisory Committee (LAC)," which will be formally established after approval by the OAC. The members will serve in an advisory capacity to the project staff for the life of the project. While the membership of each LAC will be different, all will include consumers and/or family members, providers, system partners and MHD staff. Each LAC will perform three critical tasks. First prior to initiating services, the LAC will help staff members finalize project success measures, monitoring tools and reporting infrastructure. Second, while the project is being implemented, the LAC will meet on a regular basis (e.g. quarterly) to review the project's progress and outcome data. Third, LAC members assess the project's efficacy, assist in preparing and presenting final reports, and create opportunities for disseminating information, integrating practices or replicating services based on lessons learned.*

- *Throughout the process, each Learning Advisory Committee will be supported by a professional program evaluator who will be assigned to each project. This resource will need to be procured and deployed in support of each project. The evaluators will serve as an additional resource to the MHD's Decision Support team.*

- *In addition, the MHD will add 1.0 full time staff persons to both the Adult/Older Adult and the Family & Children Divisions. These two operating divisions are responsible for implementing and monitoring all program services. They assume a primary role once the services are ready to be initiated. The addition of two staff persons will ensure that the INN projects are implemented expeditiously and monitored regularly. Each "Project Coordinator" will be assigned several INN projects and will assist in supporting the Learning Advisory Committees. The MHD will reassess the permanency of these positions upon completion of the initial projects since the projects are time-limited and because funding for the INN component will fluctuate significantly over the next several fiscal years.*

5. Why do these programs qualify as innovative programs? *A project meets the OAC's guidelines for being "innovative" if it 1) introduces new mental health practices/approaches, 2) changes existing ones, or 3) introduces new applications or practices/approaches that have been successful in non-mental health contexts. How each project meets these requirements is answered in the "Contribution to Learning" section of the Work Plan Narrative (Exhibit C) and will be discussed in more detail during each project's presentation.*

6. Where will the projects be located? *Although the specific location for each project has not yet been determined, the general method for delivering the service/activity – at a central location, at clients' residences, in pediatrician's offices, etc. – is identified in the "Project Description" section of the Work Plan Narrative (Exhibit C) and will be discussed during the presentation.*

7. Would the project have staff members who speak languages other than English and be culturally sensitive? *While the specific language requirements will vary by project, the MHSA General Standards require the services to be provided in a culturally competent manner. At a minimum, the MHD is responsible for ensuring that services can be provided in the threshold languages. The answer to this question for each specific project can be found in the "Project Description" section of the Work Plan Narrative (Exhibit C) and will be discussed during the presentation.*

8. What outcomes measures will be used to evaluate the projects? Why can these outcomes not be identified and discussed before the start of the projects? (Each project under Project Measurements has "Data Collection and Quantitative and Qualitative analysis" but does not list what will make this up and what results would be considered a success and what would be considered a failure.) *The Work Plan Narratives have been revised to include statements that articulate each project's aim and success measures. These measures and the methods for their collection and evaluation will be finalized in conjunction with the Learning Advisory Committees prior to the initiation of services. The answer to this question for each specific project can be found in the project's "Aim Statement," Work Plan Description (Exhibit D) and the Work Plan Narrative (Exhibit C); moreover, these answers will be discussed during the presentation.*

9. How will these projects sustain themselves after the funding ends in 2 to 3 years? *While INN funds cannot be used to sustain a project indefinitely, the Learning Advisory Committees, stakeholders and the MHB will be involved in recommending how the lessons learned from each project can be "sustained." As indicated in the "Timeline" section of each Work Plan Narrative (Exhibit C), this question will be taken up well before a project is scheduled to end. Although an obvious method would be to redirect other funds to an INN program/service, the results from an INN project could impact the system in ways that would require little or no County funding. For example, the lessons learned could convince providers to alter existing approaches or service delivery methods, change departmental policies, or access other funding sources. The methods specific for each project can be found in the project's "Aim Statement," Work Plan Description (Exhibit D) and the Work Plan Narrative (Exhibit C); moreover, these answers will be discussed during the presentation.*

10. What product or outcome is expected by the MHD from the MHSA Innovation Projects, and how will these impact the annual plan for future years? *Each INN project is expected to contribute to learning by "providing an opportunity to try out new approaches that can inform the current and future practices/approaches in communities." The lessons learned – from successes and failures – could be used to modify current practices or replace entire programs and services. Although not the focus of the INN component, each INN project will produce tangible benefits to clients and the system in the form of services, equipment, partnerships, training, new service delivery models and*

research. The "product" for each project can be found in the project's "Aim Statement," Work Plan Description (Exhibit D) and the Work Plan Narrative (Exhibit C); moreover, these answers will be discussed during the presentation. (Please also see question #9.)

11. Are the programs implemented as approved, (9 Strategic Plans)? What Quantitative Data is available?

A) *As part of the County's FY08-09 Annual Update, the MHD consolidated the original CSS Plan's 20 work plans into nine work plans, which have mostly been implemented as approved. By implementation, the County is referring to the processes associated with the programs, services or activities (such as needs assessments) that were identified in the original plan and/or as modified and endorsed by local stakeholders. Generally speaking, FSP, other direct service and outreach programs were implemented as approved. The MHD experienced some delays associated with contractual, logistical or procurement processes inherent in starting new services in a public mental health system. Other challenges resulted from the need to forge more formal collaborations with key system partners (juvenile justice systems, foster care systems, etc.) in order to integrate services. A summary of each CSS work plan, its target population, strategies and current programs is described in the "CSS Plan Summary Documents," which has been provided as part of the SLC/MHB packet.*

There are two key differences between CSS implementation and the approved plans. First, the original CSS plan called for the development of a time-limited pilot program to address "first breaks" or the "first onset" of mental illness among transition age youth. Since the CSS plan only allocated "one-time" funds for the program, the County determined that the intended goals of the program would be better met and sustained under the PEI component (see PEI Program/Project 3). Second, while the County has implemented one centralized Mental Health Urgent Care program, the original plan called for two additional smaller sites in the northern and southern regions of the County and for mobile crisis response capabilities. Both goals remain integral to increasing residents' access to non-emergency mental health services. As MHUC operations are optimized, the County will develop appropriate implementation strategies in light of projected decreases in MHSA funds.

In addition, while the County has had success incorporating consumers and family members in direct service roles (80-90 individuals) and in system planning, staff and stakeholders acknowledge that the outcomes are far short of intentions. The County will continue efforts to develop more cohesive and robust family member-run and consumer-run programs. These efforts will be integrated with related programs under WET, PEI, INN and CFTN.

B) *Currently, quantitative data is available, but with significant limitations. First, outcome data (changes for clients) is extremely difficult to*

obtain and present systematically. With significant effort, the MHD can provide outcome data for specific programs such as the FSP-90 program operated by Momentum for Mental Health. With even greater effort the MHD can provide some outcome data for very similar programs such as all FSP programs serving TAY. However, because the MHD is still developing standardized, global performance measures, outcome data for entire systems of care (e.g. all adults) cannot be provided because of differences in service levels, need, budgets, etc. Requests for outcome data should be made for specific programs with time dedicated for in-depth presentations.

Second, while utilization data for treatment services are available, utilization data for outreach and engagement services are generally softer and more prone to error. For example, the ECCACs diligently track the services they provide, but since they must do so manually, there is often greater room for error. Similarly, there are challenges related to determining the number of unduplicated clients that CSS work plans or programs serve. Quarterly, the MHD reports on the number of clients served by each CSS work plan. However, there is often significant overlap between CSS work plans and between CSS and "non-CSS" programs. As a result the reported numbers are generally very useful for understanding the progress of specific programs, but are less useful when trying to gauge the progress of an entire work plan. For example, CSS Work Plan A-01 consists of nearly $24 million in programs and services that are both stand-alone and augmentations or expansions of existing programs.

While quantitative data is limited, it does exist, and can be utilized to develop informative reports. Both the MHD and stakeholders should continue to refine reports, improve capabilities (e.g. redeploying an Electronic Health Record), standardize performance measures, and communicate expectations and limitations in order to make the best-informed decisions as possible.

After all presentations were delivered and time provided for questions for each project, the SLC voted to approve the FY10-11 Annual Update, Supplemental Assignment of PEI funds, and all 8 Innovation plans.

Additional Comments/Responses for July 19 SLC Meeting.

Written Comment from Hope Holland after the MHB Meeting:
The Community Supports (INN) projects 1 (through) 8, and has been part of the planning process. No one in the community objects and I wish to inform the Board of Supervisors that the only objection from the community was an objection to the Mental Health Board.

Comment Received 7/20/19 (Anonymous) I am concerned about the Mental Health Department's summation of the Community Services

and Supports phase of MHSA implementation in Santa Clara County. In "Answers to Mental Health Board Questions" on page 5, the MHD states that there are two "key differences" between the CSS Plans as approved and as implemented. As an explanation of the second of these key differences the MHD provides a mere three sentences: *"In addition, while the County has had success incorporating consumers and family members in direct service roles (80-90 individuals), and in system planning, staff and stakeholders acknowledge that the outcomes are far short of intentions. The County will continue efforts to develop more cohesive and robust family member-run and consumer-run programs. These efforts will be integrated with related programs in WET, PEI , INN , and CFTN."*

This brief paragraph is deeply disappointing to me, as a family member, a member of the community, and a County employee. The involvement of family members and consumers in the planning and delivery of services, and in the transformation of the system, was a key goal of the Mental Health Services Act. For the County MHD to say only, that outcomes fell short of intentions, gives short shrift to this key component of the CSS plans, and it gives no explanation, and holds no one accountable, for this implementation failure. Further, the one success that is touted, the incorporation of consumers and family members in direct service roles, is misleading when in reality virtually all of these 80-90 individuals are employed in non-permanent, non-benefited, part-time, contracted positions, which have not been fully integrated into County-operated programs, and two of the permanent positions the MHD created for program managers to lead this effort have been eliminated. Finally, the statement that the Department will continue efforts to develop family member-run and consumer-run programs is rendered meaningless by the absence of any mention of the commitment of funds, or identification of individuals in the administration who will be responsible and accountable for these efforts.

As the stakeholders consider plans for future components of the Mental Health Services Act, it is important to keep in mind the Department's track record with the implementation of previous components of the CSS plans, and, in light of this track record, it is important for the Mental Health Board to continue to provide appropriate oversight and accountability with respect to the County's use of MHSA funds.

MHD Response: *The MHD continues to pursue the development of a multi-level mental health peer partner classification. The classification is under review by County human resources. Excluding consumer and family positions that are funded as part of contracted services, the CSS plan includes over $1.7M for consumer and family member positions. Under PEI, approximately $1 million are set aside for consumer and family member positions. Finally, under the WET component, approximately $450,000 are set aside to help recruit, train and incorporate consumer and family members into direct service roles. Peer and Family Partners will have significant paid roles in the implementation several of the County's TN projects. Under INN, peers and family members play significant roles in Project 2, 5, 7 and 8.*

Please contact Ky Le, MHSA Project Manager, at 408-885-7543 or ky.le@hhs.sccgov.org.

DRAFT UNTIL REVIEWED and APPROVED BY THE MENTAL HEALTH BOARD

COUNTY of SANTA CLARA MENTAL HEALTH BOARD
Public Forum Quarterly Evening Meeting, July 19, 2010
Mental Health Services Act (MHSA)

MINUTES

1. The Public Forum quarterly evening meeting of the Santa Clara County Mental Health Board (MHB) was called to order at 9:24 p.m. by Chair Cheryl Crose. The meeting took place at IBEW Hall, 2125 Canoas Garden Avenue, #100 in San José, CA; following the conclusion of the Stakeholder Leadership Committee meeting.

   Roll Call: Llolanda Ulloa called roll, please reference attached sign-in sheet for attendees.

Members Present:	**MH Department Staff:**
Cheryl Crose, Chair	Dr. Peña, Director of MH Department
Ronald Henninger, 1st Chair	Bruce Copley, Deputy Director of MH Department
Charles Pontious, 2nd Chair	Pat Garcia, Director of Administration, MH Department
Clinton Brownley	Llolanda Ulloa, MH Board Support
Tito A. Cortez	Ky Le, MHSA Project Manager
Julianna Brooks	Elena Tindall, PEI Consultant
Jacqueline Gutierrez	Gabriela Deeds, MH Program Specialist
David Mariant	
Wesley Mukoyama	
Victor Ojakian	

Members Absent *** = Excused Absence**
Supervisor Dave Cortese *
Richard Loek*
Margene Chmyz *
Hilbert Morales *
Henry Morillo

2. Chair Crose commented on the collaboration between the Mental Health Board and Mental Health Department, and thanked all that worked in putting the presentations together for the public and the MHB.

3. There were no public comments made at this time.

4. Dr. Henninger, First Vice Chair of the MHB commented that this public meeting is very educational and it solidified the plans. As a MHB member, he is happy to see that the plans are really coming together. Had this occurred six months ago, it would have made it easier for the MHB to move forward with the plans. He commented that putting out a plan that is not well thought-out would affect the patients. He requested complete information be made available ahead of time for review.
   - MHB member, David Mariant also thanked the staff and MHD for producing the information ahead of time; it was useful to him in making his decisions.

5. The Supplemental Assignment of PEI Statewide Project Funds was opened for discussion and comments. The following action occurred: Victor Ojakian moved and Tito A. Cortez seconded to accept option (a),

"To advise the BOS approve the plan as submitted." Discussion followed. **Vote: 9 Ayes, 0 (zero) "Nays" and 1 Abstention** by David Mariant. **Motion passed**.

6. The Mental Health Board took the following action on the FY 10-11 Annual Update was moved by Victor Ojakian and seconded by Tito A. Cortez to accept option (a), "To advise the BOS approve the plan as submitted." Discussion followed with Mr. Mukoyama asking if there will be any specific older adult program in the plan. Mr. Le replied that there are two: Full Service Partnership Program for older adults with capacity of 25; the other is an outreach in-home case management program called Golden Gateway. Also, in PEI Project 4, there is a behavioral health interventions for Adults and Older Adults-Mr. Mukoyama stated that this project is not Older Adult-specific. **Vote: 6 Ayes, 3 Nays,** by Mr. Mukoyama, Ms. Brooks and Ms. Gutierrez; and **1-Abstention** by Mr. Mariant. **Motion passed.**

7. With INN Projects, the MHB took the following action: Julianna Brooks moved and Jacqueline Gutierrez seconded to go with C, "to advice that the BOS not approve the plans and provide written recommendation." Discussion followed with Ms. Brooks' comment that this is specifically regarding plan 8; adding that there is a robust program already to augment that program; she would like the MH Board to know the overhead cost $823K/year is very high.
   - Mr. Ojakian moved with a friendly amendment; to vote on the approval of items 1-7 separate from item 8 and have discussion only on item 8; noting that the motion maker accepted this friendly amendment. Discussion continued on only item 8. Mr. Ojakian asked Mr. Le, what would happen to unexpended funds; in response, the plan is to use them on approved plans; the unspent funding would be used first in the next Fiscal Year to avoid loss of funds. Ms. Gutierrez asked for clarification on duration of projects in years. Dr. Peña answered that these are innovation and intended for three years; once the project learning process is over; then it would be RFP to a contract.
   - Regarding Budget and allocation of funds, the MH Board members will be asked to participation in the process.
   - The ability for the MH Department to terminate a plan was brought up by Ms. Gutierrez and the reply by Dr. Peña was that if a project does not get off the ground and not doing well, the department has the right to terminate it with a 30-day notice; this is the language in contracts and the public process would be used; it would be open and transparent.
   - Dr. Henninger expressed concern with outcomes not being well defined and asked that literature with outcomes be used in some of these plans.

   Public comment
   a. By Mr. Dwyer; he said that the current officer training is only 6-hours regarding MH. Palo Alto has committed to train 100% of their officers. Mr. Dwyer added that 25% of the police force in the County will be trained and debriefing will be included. CIT will not take the place of the training and will only reach 25% of the force; Mr. Dwyer added that if officers are not trained in MH, change will not happen.
   b. MHB member, Mr. Pontious said the problem is that the police officers are not trained and this training should be done in the police academy. For the record, he approves of these funds being spent for CIT Training, though feels it is a band-aid job.
   c. MHB member, Mr. Ojakian commented that he and Julianna Brooks teach CIT in San Mateo County who will receive cuts; this speaks to the fact that more schools are needed. The effort is for the training to be institutionalized and there is consistency at a high-level. Mr. Ojakian there is a friendly amendment on the table to move on voting items 1-7 because no one is talking about those items. The motion was not seconded; therefore Mr. Ojakian made an unfriendly amendment to approve those items. David Mariant seconded and discussion continued.
   d. Erick Torregroza stated that we cannot be sure if any of the plans, including number 8, will work or not because they are new approaches that are being tested. He recommended for the MHB to vote in favor of item 8; stating that more training for police officers will benefit people with mental health concerns.

e. Hope Holland commented that officers' training materials aren't available for consumers and pointed out that consumers may educate about Mental Health through the video so officers can better understand.
f. Chuan Pham wants to support the innovation plan item 8. He also addressed another problem for consumers who work regarding Social Security benefits; with consumers going hungry. He also addressed a concern about with consumers' relationships with others. Mr. Pham asked for help by Mental Health Department to make life better and feels CIT training will aid in that.
g. Jose Rangel, commented on the importance of not leaving the less fortunate behind.
h. Andrew Phelps commented the entire system of social relations in the engagement of psychological support needs to change. He reminded the MHB and the SLC that a proposal he submitted at the 10/2009 meeting for selection of Innovation projects was displaced.
i. MH Board member Julianna Brooks comment that she is willing to vote for item 8 as long as it is reported back by the first year. At this point, David Mariant withdrew his second and Victor Ojakian withdrew his unfriendly amendment to the motion. The amended motion by Julianna Brooks remains on the floor. Dr. Peña commented that the project could be amended if necessary through annual updates. However, it is important to note that this project has a three-year timeframe because the department has estimated that this is the length of time necessary to assess progress towards identified success mearues. Also, she commented that thereis no budget in CIT to produce a video.
j. Dr. Henninger asked if updates are required quarterly, the response is yes; Dr. Peña let the MHB know they may ask for them more frequently.

- Clarification was asked on whether there was a motion on the floor. At this point the MHB agreed to vote on items 1-7 as Victor Ojakian moved and David Mariant seconded; discussion continued. **Vote: 6 Ayes**, **4 Abstentions and 0 (Zero) Nays**, **Projects 1-7 Passed**.

Vote on INN Project 8 is as follows: Victor Ojakian moved and Charles Pontious seconded to approve Plan 8 as submitted. Vote: **7 Ayes, 2 Nays (Julianna Brooks and Jacqueline Gutierrez), and 1 Abstention. Project 8 passed.**

8. The MHB Public Forum adjourned at 10:20 p.m.

These minutes are respectfully submitted by Llolanda Ulloa, Mental Health Board Support.

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Summary of Substantive Changes to INN Plan

Component-Wide and/or Administrative Changes

1. **OAC Recommendations.** In response to courtesy reviews by the Oversight and Accountability Commission (OAC) staff revised project narratives to improve logic, flow, organization and support for projects. Conducted further research and documentation of needs.
2. **Aim and Success Measures.** For all projects, developed concise statement of aim and success measures, which include both process milestones (e.g. completion of a training model) and outcomes for clients, programs or systems.
3. **System Value.** For all narratives, summarized how the lessons learned from each project would impact the existing system of care.
4. **Aim Statements.** Developed "Aim Statements" for each project. These concise descriptions include the (1) Community Need, (2) Aim, (3) Project Strategies, (4) Success Measures, and (5) System Value.
5. **Learning Advisory Committees (LAC).** Refined roles of the LACs including their role in helping to finalize success measures, data tools/instruments, and service or training models.
6. **Timelines.** Refined timelines to account for an October approval date, participation of LACs, and to build in time to assess how the lessons learned from each project could be incorporated into the existing system of care.
7. **Outreach.** Described possible outreach strategies to inform clients of project services.
8. **Budget Narratives.** As part of a new requirement by the OAC, the MHD developed and included budget narratives for each project and for MHD administration of INN.
9. **Project Budgets.** Refined all project budgets to streamline calculations for general operating and indirect expenses. The MHD developed more concise expenditure projections for each project by fiscal year based on the proposed programs and duration. Major changes, if any, to individual project budgets are described below.
10. **MHD Administration.** In order to implement the projects as quickly as possible, the MHD has proposed adding two staff positions to assist with the launch of the eight projects and the LACs.
11. **Evaluation.** Designated ongoing resources to evaluate each of the projects.

INN-01: Early Childhood Universal Screening Project

12. Met with Pediatric and KidScope staff to identify barriers to screening and received suggestions for feasible implementation of project in public outpatient pediatric clinics.

INN-02: Peer Run TAY Inn

13. Increased funding to account for possible facility expenses and for the program to be implemented as a completely new program or as a modification of an existing program.

INN-03: MH Disorders in Adults with Autism / Developmental Disabilities

14. Researched and documented need for a limited needs assessment to better define local prevalence and systemic barriers to treatment.

Summary of Substantive Changes to INN Plan

INN-04: Older Adults

15. Researched and documented need in terms of projected older adult population growth and current service disparities.
16. Researched clinical literature and established effectiveness of techniques of reminiscence and life review with older adults in group homes, and their impact on severe depression and dementia. Added success measures on depression and cognitive decline.
17. Described life-review/story telling technique.
18. Refined justification for number of clients served (180).

INN-05: Multi-Cultural Center

19. Clarified innovation aspect of the project, which is to facilitate cross-cultural collaboration between ethnic communities in one center in order to increase access and engagement and improve quality of life for underserved individuals and their families.
20. Described Multi-Cultural Center services and explained need for governance model.
21. Defined major milestones for project implementation:

    1) Assembling of an Advisory Board of Directors (Board) composed of leaders and representatives of ethnic communities;

    2) Completion of an MCC governance model endorsed by the Board;

    3) Completion of an ethnic-grounded service program endorsed by the Board;

22. In case re-use facilities or in-kind contribution cannot be obtained, the MHD budgeted for the facility expenses of a 10,000 sft. space. Additional staffing was added to ensure that the MCC would be able to be staffed during evening and weekends, as well as accommodate and support yet-to-be-identified volunteers and community groups.

INN-06: Transitional MH Services to Newly Released County Inmates

23. Researched and documented high prevalence of mental health problems in newly released county inmate population.
24. Conducted literature review about effectiveness of faith organizations efforts to improve reentry. Confirmed that lack of organizational capacity appears to be a barrier to effective service delivery and achieving positive outcomes.

INN-07: Mental Health / Law Enforcement Post-Crisis Intervention

25. Provided more description on post-crisis response and interaction with law enforcement.

INN-08: Interactive Video Scenarios Training

26. Enlisted assistance of law enforcement liaisons and consumer representatives to identify preliminary qualitative and quantitative data indicators to measure success of model.
27. Increased program to three years. Stakeholders indicated that two years was insufficient to assess the effectiveness of the training since the videos would be developed in FY11 and officers would start training in FY12, and utilize their skills in FY12 and FY13.